Commonwealth
INDEMNITY PLAN
COMMUNITY CHOICE

Member Handbook for Active Employees
and Non-Medicare-Eligible Retirees

SERIES 5
EFFECTIVE
JULY 1, 2004

Commonwealth
Indemnity Plan
Administered by UNICARE

UniCare®

Table of Contents

Part 1: Medical Plan

Important Telephone Numbers (toll free)

Medical Benefits	Prescription Drug Plan	Mental Health, Substance Abuse and Enrollee Assistance Programs
1-800-442-9300	1-877-828-9744	1-888-610-9039
TDD: 1-800-322-9161	TDD: 1-800-842-5754	TDD: 1-800-842-9489

Welcome to the Commonwealth Indemnity Plan Community Choice

Overview

This handbook is a guide to benefits for you and your covered dependents under the Commonwealth Indemnity Plan Community Choice (Community Choice Plan). These benefits are provided through the Group Insurance Commission (GIC), the state agency responsible for the design and payment of all benefits for state employees, retirees and their dependents. This Plan is funded by the Commonwealth of Massachusetts and administered by UniCare.

UniCare provides administrative services for the Commonwealth Indemnity Plan Community Choice such as claims processing, customer service, utilization management and medical case management at its Commonwealth Service Center in Andover, Massachusetts. UniCare is not the insurer of the Community Choice Plan.

Throughout this handbook, the Commonwealth Indemnity Plan Community Choice is referred to either by its full name, as the "Community Choice Plan" or as the "Plan." The Group Insurance Commission is referred to as the "GIC."

To fully understand your benefits, please read this handbook carefully.

How This Handbook Is Organized

Descriptions of the benefits available to you and your covered dependents are provided in the following three parts of this handbook:

Part 1: Medical Benefits

This part of the handbook describes the benefits available under the Community Choice Plan for medical services, treatment and supplies. These benefits are administered by UniCare. See page 2.

Part 2: Prescription Drug Plan

This part of the handbook describes the prescription drug plan, which is administered by **Express Scripts.** See page 65.

Part 3: Mental Health, Substance Abuse and Enrollee Assistance Programs

This part of the handbook describes the Mental Health, Substance Abuse and Enrollee Assistance Programs for the Community Choice Plan, which are insured by **United Behavioral Health (UBH)**. See page 71.

If you have questions about any of your benefits, please refer to the contact information on page 7.

About Your Medical Plan

Community Choice provides comprehensive coverage for many health services including hospital stays, surgery, emergency care, preventive care, outpatient services and other medically necessary treatment. As a Plan member, you may go to the physician and hospital of your choice. However, you will pay lower deductibles and copays for hospital care when you receive care at a Community Choice Hospital or at one of the hospitals designated for high-risk maternity care or certain Complex Procedures.

Physician Services

Your Plan benefits for physician services are the same regardless of which physician you see. As a Community Choice member, you are not required to choose a primary care physician, and you do not need a referral to see a specialist. There is no physician network, so you don't need a physician directory.

For help with your hospital and physician choices, contact a Member Care Specialist at the Commonwealth Service Center at 1-800-442-9300. This individual will work closely with you to help you manage your health care choices and direct you to appropriate health resources. Member Care Specialists can also assist you in finding physicians who are affiliated with Community Choice Hospitals where you will have lower deductibles and copays for inpatient and outpatient care. See page 5 for more information about the various ways our Member Care Specialists can assist you.

Hospital Services

With the Community Choice Plan, there are variable deductibles for inpatient and outpatient hospital care. You have the lowest deductibles and copays when:

1. You use hospitals on the Community Choice Hospital listing (see Appendix E)
2. You get admitted to a hospital through the emergency room
3. You have one of the Complex Procedures listed in Appendix F performed at one of the Designated Hospitals listed in Appendix F
4. You receive care at any acute rehabilitation facility, or
5. You receive transplant services at any of the Quality Centers and Designated Hospitals for Selected Transplant Services. Call a Member Care Specialist for more information.

For all other inpatient and outpatient care, you pay higher deductibles and copays. For details, see “Deductibles” in the Your Costs section, as well as the Benefit Highlights section.

Using Non-Massachusetts Providers

For information about receiving services from non-Massachusetts providers, please refer to "Charges Over the Reasonable and Customary Allowed Amount" on page 11 as well as Appendix B: "What You Should Know When You Use Non-Massachusetts Providers."

How to Receive the Highest Level of Benefits from Your Medical Plan

Please read the following information carefully to ensure that you receive the maximum level of Plan benefits for medically necessary services.

- **You or your provider must notify the Commonwealth Service Center at 1-800-442-9300 for all hospital admissions and certain selected outpatient procedures and services.** The **telephone symbol** ☎ you see throughout this handbook lets you know that, to obtain the maximum level of benefits, you or your provider must call the Commonwealth Service Center. Failure to do so will result in a reduction in benefits of up to $500. However, you do not need to call the Plan if you are outside the continental United States (the contiguous 48 states).

  Please refer to the Managed Care section of this handbook for specific notification requirements and responsibilities.

- **Use Community Choice Hospitals for hospital care.** For a comparison of benefits when you use Community Choice Hospitals versus non-Community Choice Hospitals, refer to the Benefit Highlights section. Also see "About Your Medical Plan" on page 2 .

- **Use the Plan's Preferred Vendors** for the following services to enhance your level of benefits:

  – outpatient laboratory services
  – durable medical equipment
  – medical/diabetic supplies
  – home health care
  – home infusion therapy

 For a list of the Plan's current Preferred Vendors, log onto the Plan's web site at **www.unicare-cip.com**, or call the Commonwealth Service Center at 1-800-442-9300.

- **Carry your Community Choice Plan ID card with you at all times and always show it to your provider when you go for care.** This enables your provider to confirm your eligibility for Plan benefits.

- If you live outside Massachusetts – either permanently or on a temporary basis for more than four consecutive weeks – and receive services from non-Massachusetts providers, see "Charges Over the Reasonable and Customary Allowed Amount" on page 11 as well as Appendix B: "What You Should Know When You Use Non-Massachusetts Providers" at the back of this handbook.

Online Access to Medical and Plan Information on the Plan's Web Site

For your convenience, you can access a broad range of Plan-related and general health care information on the Plan's web site at **www.unicare-cip.com.**

The **computer symbol**  that you see throughout this handbook indicates that information on the highlighted topic is available on the Plan's web site. For example, www.unicare-cip.com can help you by giving you information about how to:

- access information for making health care decisions
- select a hospital where you can receive care at the lowest deductibles and copays
- obtain information about your claims
- check out the Plan's discounts on products and services
- e-mail the Plan or order Plan materials
- view the Plan's Member Handbook online

Important Plan Information

Overview

This section gives you important information about the Community Choice Plan, including:

- the Commonwealth Service Center and how its Member Care Specialists and Patient Advocates can help you
- the process for ordering new identification cards
- the steps to take to access a language interpreter when speaking with a Member Care Specialist at the Commonwealth Service Center
- contact information when you have questions about your medical plan; prescription drug plan; or mental health, substance abuse and Employee Assistance Programs
- the Plan's Member Confidentiality Statement

The Commonwealth Service Center

The Commonwealth Service Center is where UniCare administers services; processes claims; and provides customer service, utilization management and medical case management for the medical component of the Community Choice Plan. Member Care Specialists are available Monday through Friday from 8:30 a.m. to 5:00 p.m. to answer questions you and your family may have about your medical coverage. You can also access claims information 24 hours a day, seven days a week from our automated telephone line, or from the Plan's web site at **www.unicare-cip.com**.

When you call, you will speak with a Member Care Specialist or Patient Advocate, depending on the nature of your call.

Member Care Specialists: Here to Help You

Member Care Specialists are the Plan's specially trained customer service representatives who you can contact for assistance with your health plan questions and concerns. They do not act as a gatekeeper, but simply to help you manage your health care choices and direct you to appropriate health resources.

Member Care Specialists can:

- Help you choose an appropriate hospital or Preferred Vendor for the care you need so you receive the highest level of coverage
- Assist you in finding physicians who are affiliated with Community Choice Hospitals where you will have lower deductibles and copays for inpatient and outpatient care
- Put you in touch with the Plan's nurse health educators
- Provide you with information about supportive health care programs offered by the Plan
- Answer questions about the Plan's notification requirements
- Provide answers to general benefit and coverage questions

Connecting to Support – As indicated above, Member Care Specialists can also help members who would benefit from additional assistance. Based upon your health care need, the Member Care Specialist may direct you to:

- **Health improvement programs** where registered nurses help you work with your

doctor to actively manage chronic conditions such as congestive heart failure, diabetes and asthma

- **MedCall**, a toll-free telephone line that connects you to a registered nurse or audiotape library that is available 24 hours a day, seven days a week
- **Utilization management**, a review process for surgeries and hospitalizations
- **Case management**, where registered nurses assist you and your family when you are faced with a serious medical problem.

Patient Advocates

Patient Advocates are registered nurses who can help you coordinate your health care needs with the benefits available under the Plan. The Patient Advocate will:

- provide information about the Managed Care Program, including Utilization Management, Medical Case Management, and Quality Centers for Transplant Services and other services
- answer questions about the Plan's coverage for hospital stays and certain outpatient benefits
- speak with you and your physician about covered and non-covered services to help you obtain care and coverage in the most appropriate health care setting and let you know what services are covered, or
- assist you with optimizing benefits for covered services after you are discharged from the hospital

Your Identification Card

When you are enrolled in the Plan, you will receive an identification (ID) card. Be sure to present your ID card to your provider when you seek medical care. Your card contains useful information about your benefits and important telephone numbers you and your doctor may need.

If you lose your ID card or need additional cards, you can order new cards from the Plan's web site at **www.unicare-cip.com**. You can also call the Commonwealth Service Center at 1-800-442-9300.

Interpreting and Translating Services

If you need a language interpreter when you contact the Commonwealth Service Center, a Member Care Specialist will access a language line and connect you with an interpreter who will translate your conversation with the Member Care Specialist.

If you are deaf or hard of hearing and have a TDD machine, you can contact the Plan by calling its telecommunications device for the deaf (TDD) line at 1-800-322-9161 or 1-978-474-5163.

Member Confidentiality Statement

This statement describes how UniCare protects the confidentiality of Community Choice Plan members' personal financial and health information. It also explains your rights as well as UniCare's legal duties and privacy practices. UniCare's policies comply with the Health Insurance Portability and Accountability Act (HIPAA) that was signed into federal law in August 1996 to help improve the efficiency of the health care system in the United States.

The Plan's Member Confidentiality Statement is contained in Appendix A at the back of this handbook. Please read this statement carefully.

Important Contact Information

If you have questions, please refer to the contact information below:

For information about your medical benefits:

Commonwealth Indemnity Plan
Community Choice
P.O. Box 9016
Andover, MA 01810-0916
1-800-442-9300 (toll free)
TDD: 1-800-322-9161
www.unicare-cip.com

For information about your prescription drug plan:

Express Scripts
1-877-828-9744 (toll free)
TDD: 1-800-842-5754
www.express-scripts.com

For information about your mental health and substance abuse benefits:

United Behavioral Health
1-888-610-9039 (toll free)
TDD: 1-800-842-9489
www.liveandworkwell.com
(access code: 10910)

Your Costs

Overview

This section describes the costs that you may be responsible for paying in connection with services covered by the Plan. These costs include deductibles, copayments and coinsurance. This section also explains how the Plan reimburses health care providers.

Deductibles

A deductible is a fixed dollar amount you pay for certain services before the Plan begins paying benefits for you or a covered dependent. There are two types of deductibles: those for inpatient hospital care and those for outpatient hospital care. These deductibles vary depending on the hospital you use and the circumstances under which you are admitted. The chart below shows the deductible amounts you must satisfy based on where you receive hospital care.

Inpatient Hospital Deductibles

Where You Receive Hospital Care	*Inpatient Hospital Deductible*
You pay the lowest deductibles and copays when: 1. You use hospitals on the Community Choice listing (see Appendix E) **OR** **when you use non-Community Choice Hospitals in the following situations:** 2. You have one of the Complex Procedures listed in Appendix F performed at one of the Designated Hospitals in Appendix F 3. You get admitted to any hospital through the emergency room 4. You receive care at any acute rehabilitation facility, or 5. You receive transplant services at any of the Quality Centers and Designated Hospitals for Selected Transplant Services	$200 per calendar quarter
You pay higher deductibles and copays when: You use any hospital other than those specified above	$750 per admission

1. **When you use a Community Choice Hospital or one of the hospitals under the circumstances specified in items 2–5 in the chart on page 8,** the inpatient deductible is $200 and applies on a per-person, per-calendar year quarter basis. When you or a covered dependent is admitted to a hospital, you are responsible for this deductible. However, once a covered person satisfies this deductible in any single calendar year quarter, he or she will not have to satisfy the deductible again during that same calendar year quarter.

For example: If you are admitted to a hospital in January to any of the hospitals specified in items 1–5 in the chart on page 8, and stay overnight, you will be responsible for paying the $200 deductible. If you were re-admitted to one of these hospitals in March, you will not have to pay another deductible, as March is in the same calendar quarter as January. However, if you were re-admitted to one of these hospitals in May, you will incur another $200 deductible.

2. **When you use a hospital other than as specified in items 1–5 in the chart on page 8,** the inpatient hospital deductible is $750 and applies on a per-person, per admission basis. When you or a covered dependent is admitted to a hospital other than those listed in items 1-5 in the chart on page 8, you are responsible for this deductible.

Outpatient Surgery Deductibles

The following chart compares the deductibles you pay for outpatient hospital care, depending on where you receive care:

At a Community Choice Hospital	At a Non-Community Choice Hospital
$75 per quarter	$250 per occurrence

1. **When you use a Community Choice Hospital** – The outpatient surgery deductible is a per-person, per-calendar year quarter deductible when using a Community Choice Hospital. When you or a covered dependent has surgery at a hospital you are responsible for paying this deductible. However, once a covered person satisfies the outpatient surgery quarterly deductible in any calendar year quarter, he or she will not have to satisfy this deductible again during that same calendar year quarter.

For example: If you have outpatient surgery in January at a Community Choice Hospital, you will be responsible for paying the $75 deductible on the hospital charges. If you have another surgery in March, you will not have to pay another deductible, as March is in the same calendar year quarter as January. However, if you have surgery at a hospital in May, you will incur another $75 deductible.

2. **When you use a non-Community Choice Hospital** – The outpatient surgery deductible is a per-person, per occurrence deductible. When you or a covered dependent has surgery at one of these hospitals, you are responsible for paying this deductible.

Coinsurance

Coinsurance is the percentage of the allowed amount that you must pay for covered services after the deductible is satisfied. For example, if the Plan pays 80% of the allowed amount for certain services, you are responsible for paying the remaining 20%. In addition, you may be responsible for the difference between the allowed amount and the providers's charge for services received from providers outside of Massachusetts. To see which benefits coinsurance applies to, refer to the Benefit Highlights Section.

Your Costs

Copayments

A copayment ("copay") is a fixed dollar amount you pay to a provider at the time of service. Copay amounts vary depending on the type of service you receive and whether you receive care at a Community Choice Hospital or a non-Community Choice hospital. (See Benefit Highlights section for copays for each type of service.) Copayments do not count toward satisfying deductibles, coinsurance amounts or out-of-pocket maximums.

***For example*:** If you are a member of the Plan and you or a covered dependent go to a physician's or chiropractor's office, you or your dependent will pay a $10 copay at the time of the visit. Although you usually pay the copay at the time of the visit, you can also wait until the provider bills you.

Out-of-Pocket Maximum

To protect you from large medical expenses, the Plan limits the amount of coinsurance you pay out-of-pocket each year for some covered services. This out-of-pocket maximum applies to each covered person, as follows:

Community Choice Hospital	Non-Community Choice Hospital
$750	$5,000

Once you reach the out-of-pocket limit, the Plan pays 100% of the allowed amount for the designated covered services for the rest of the calendar year.

The following out-of-pocket expenses do not apply toward your out-of-pocket maximum:

- Deductibles (except for the hospital deductible for hospitals not included in items 1–5 in the chart on page 8)
- Copayments
- Certain coinsurance amounts (to find out which coinsurance amounts do not apply toward the out-of-pocket maximum, see the Benefit Highlights section)
- Amounts in excess of the Plan's allowed amounts
- Amounts for non-covered services

Reasonable and Customary Charge

Charges for covered services are reasonable and customary to the extent they do not exceed the general level of charges for like or similar treatment, services or supplies by other providers in the area where the charges are incurred. Charges in excess of the Reasonable and Customary Charge are not considered for payment under the Plan.

Reasonable and Customary Allowed Amount

The Reasonable and Customary Allowed Amount (also referred to as the allowed amount) is the amount UniCare determines to be within the range of payments most often made to similar providers for the same service or supply. This payment amount may not be the same as the provider's actual charge.

Under Massachusetts General Law, Chapter 32A: Section 20, providers who render services in Massachusetts are prohibited from billing you for amounts in excess of Plan determined or allowed amounts.

The Plan has established Reasonable and Customary Allowed Amounts for most services from providers. These allowed amounts are expressed as maximum fees in fee schedules, maximum daily rates, flat amounts or discounts from charges. This payment amount may not be the same as the provider's actual charge.

Provider Reimbursement

The Community Choice Plan reimburses providers on a fee-for-service basis. The Plan does not withhold portions of benefit payments from providers, nor offer incentive payments to providers related to controlling the utilization of services. Explanations of provider payments are detailed in your Explanations of Benefits (EOBs). Under the Plan, providers are not prohibited from discussing the nature of their compensation with you.

Charges Over the Reasonable and Customary Allowed Amount

In some cases, your provider may bill you for charges over the allowed amount. The Plan will not consider these charges for payment.

- **Massachusetts Providers:** Under Massachusetts General Law, Chapter 32A: Section 20, providers who render services in Massachusetts are prohibited from billing you for the amount in excess of Plan determined or allowed amounts. If you receive a bill for charges above the allowed amount from a Massachusetts provider, contact a Member Care Specialist to help you resolve this issue.

- **Non-Massachusetts Providers:** These providers may balance bill you for the difference between the payments made by the Plan, based on the Plan's allowed amount, and the full amount the provider charged. The charges in excess of the Plan's allowed amounts will not be considered for payment by the Plan.

- **Preferred Vendors:** Preferred vendors, whether located within or outside of Massachusetts, are contracted to accept the Plan's allowed amount. Therefore, they cannot balance bill you for any charges exceeding the allowed amount determined by the Plan. If you receive a bill for charges above the allowed amount from a Preferred Vendor, contact a Member Care Specialist to help you resolve this issue.

Your Claims

How to Submit a Claim

To receive benefits from the Plan, a claim must be filed for each service. Most hospitals, physicians or other health care providers will submit claims for you. If your provider files claims on your behalf, the provider will be paid directly. If you submit your own claim, you must include written proof of the claim that includes:

- diagnosis
- date of service
- amount of charge
- name, address and type of provider
- name of enrollee
- enrollee's ID number
- name of patient
- description of each service or purchase
- information on any other group health insurance plan(s) under which you may be covered
- accident information, if applicable
- proof of payment, if applicable

If the proof of payment you receive from a provider contains information in a foreign language, please provide the Plan with a translation of this information, if possible.

The Community Choice Plan claim form may be used to submit written proof of a claim. For your convenience, a claim form can be found at the back of this book.  You can also download or request this form from www.unicare-cip.com.

Original bills or paid receipts from providers will also be accepted as long as the information described above is included.

Filing Deadline

Written proof of a claim must be submitted to the Plan within two years from the date of service. Claims submitted after two years will be accepted for review if it is shown that the person submitting the claim was mentally or physically incapable of providing written proof of the claim in the required time frame.

Checking Your Claims for Billing Accuracy

Bill Checker Program

The goal of the Bill Checker Program is to detect overpayments that are the result of billing errors that only you, as the patient, may recognize. Just as you might do with your utility bills, the Plan encourages you to review all of your bills for accuracy. In those instances where you do detect a billing error and you are able to obtain a corrected bill from your provider, you will share in any actual savings realized by the Plan.

What You Need to Do

You must request that the provider send you an itemized bill for the services you received. As soon as possible, review this bill for any charges that indicate treatment, services or supplies that you did not receive. Check items such as:

- Did you receive the therapy described on the bill?
- Did you receive x-rays as indicated on your bill?
- Are there duplicate charges on the same bill?
- Have you been charged for more services than you received?
- Did you receive the laboratory services described on the bill?
- Does the room charge reflect the correct number of days?
- Were you charged for the correct type of room?

When Errors Are Detected

If you find an error, contact the provider or the provider's billing office and report the exact charges you are questioning. Request an explanation of any discrepancies and ask for a revised itemized bill showing any adjustments.

How to Receive Your Share of the Savings

To receive your share of the savings, you must send copies of both the original and revised bill(s) to the Plan along with the completed Bill Checker form. For your convenience, a Bill Checker form can be found in Appendix C at the back of this handbook.

 You can also request this form from **www.unicare-cip.com**. Be sure to include the enrollee's name and identification number on the Bill Checker form. The Plan will review the two bills and, if a billing error is confirmed, you will receive 25% of any savings that the Plan realizes. All reimbursements are subject to applicable state and federal income taxes.

Provider Bills Eligible Under the Program

All bills for which the Plan provides the primary benefits are eligible under the Bill Checker Program. Bill Checker is not applicable to enrollees who have Medicare as their primary coverage. This program may not apply to certain inpatient bills paid under the Diagnosis Related Group (DRG) methodology.

Claims Review Process

The Plan routinely reviews submitted claims to evaluate the accuracy of billing information about services performed. The Plan may request written documentation such as operative notes, procedure notes, office notes, pathology reports and x-ray reports from your provider.

In cases of suspected claim abuse or fraud, the Plan may require that the person whose disease, injury or pregnancy is the basis of the claim be examined by a physician chosen by the Plan. This examination must be approved by the Executive Director of the GIC and will be performed at no expense to the enrollee and/or covered dependent.

Restrictions on Legal Action

No legal action or suit to recover benefits for charges incurred while covered under the Plan may be started before 60 days after written proof of a claim has been furnished. Further, no such action or suit may be brought more than three years after the time such proof has been furnished. If either time limit is less than permitted by state law where you reside when the alleged loss occurred, the limit is extended to be consistent with that state law.

Right of Reimbursement

The Plan will have a lien on any recovery made by you or your dependent for an injury or disease to the extent you or your dependent has received benefits for such injury or disease from the Plan. That lien applies to any recovery made by you or your dependent from any person or organization that was responsible for causing such injury or disease, or from their insurers. Neither you nor your dependent will be required to reimburse the Plan for more than the amount you or your dependent recover for such injury or disease.

You or your dependent must execute and deliver such documents as may be required, and do whatever is necessary to help the Plan in its attempts to recover benefits it paid on behalf of you or your dependent.

Your Claims

Claims Inquiry

If you have questions about your claims, you can contact the Commonwealth Service Center in one of the following ways to request a review of your claim:

- Call the Plan at 1-800-442-9300.
- E-mail the Plan at www.unicare-cip.com by clicking on "Contact Us."
- Write to the Commonwealth Indemnity Plan Community Choice, Claims Department, P.O. Box 9016, Andover, MA 01810-0916.

If you have additional information, please include it with your letter. You will be notified of the result of the investigation and of the final determination.

24-Hour Access to Claims Information

You can also check the status of your claims 24 hours a day, seven days a week in the following two ways:

1. Call us at 1-800-442-9300 and select the option to access our automated information line.
2. Log onto www.unicare-cip.com. A personal identification number protects the privacy of your information.

Coordination of Benefits (COB)

You and your dependents may be entitled to receive benefits from more than one plan. For instance, you may be covered as a dependent under your spouse's plan in addition to coverage under your own plan, or your child may be covered under both plans. When you or your dependents are covered by two or more plans, one plan is identified as the primary plan for coordination of benefits (COB) and determining the order of payment. Any other plan is then the secondary plan.

If the Plan is the primary plan, benefit payments will be made in accordance with the benefits payable under the Plan without taking the other plan's benefits into consideration. A secondary plan may reduce its benefits if payments were paid by the Community Choice Plan. If another plan is primary, benefit payments under the Community Choice Plan are determined in the following manner:

(a) The Community Choice Plan determines its covered expenses – in other words, what the Plan would pay in the absence of other insurance; then

(b) The Community Choice Plan subtracts the primary plan's benefits from the covered expenses determined in (a) above; and then

(c) The Community Choice Plan pays the difference, if any, between (a) and (b).

The term *"primary plan's benefit"* includes the benefit that would have been paid had the claim been filed with the other plan. For those plans that provide benefits in the form of services, the reasonable cash value of each service is considered as the charge and as the benefit payment. All COB is determined on a calendar year basis for that part of the year the person had coverage under the Plan.

For the purposes of COB, the term *"plan"* is defined as any plan, including HMOs, that provides medical or dental care coverage including, but not limited to, the following:

- group or blanket coverage
- group practice or other group prepayment coverage, including hospital or medical services coverage
- labor-management trusteed plans
- union welfare plans

- employer organization plans
- employee benefit organization plans
- coverage required or provided by law or government programs, except Medicaid. But, such coverage will not be deemed a plan if expenses for which benefits are payable under such coverage are excluded from benefits under Community Choice Plan coverage.
- automobile no-fault coverage

The term "plan" does not include school-accident type plans, or coverage that you purchased on a non-group basis.

Determining Order of Coverage

Following are the rules by which the Community Choice Plan and most other plans determine order of payment – that is, which plan is the primary plan and which plan is the secondary plan:

(a) The plan without a COB provision is primary.

(b) The plan that covers the person as an employee, member, or retiree (that is, other than a dependent) determines benefits before the plan that covers the person as a dependent.

(c) The order of coverage for a dependent child who is covered under both parents' plans is determined as follows:

1. The primary plan is the plan of the parent whose annual birthday falls first in the calendar year; or
2. If both parents have the same birthday, the primary plan is the plan that has covered a parent for the longest period of time.

This is called the *"birthday rule."* However, if the other plan has a rule based on the gender of the parent, and, if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.

(d) The order of coverage for dependent children who are covered under more than one plan, and whose parents are divorced or separated, is determined in the following order:

1. first, the plan of the parent who is decreed by the court as financially responsible for the health care expenses of the child
2. second, if there is no court decree, the plan of the parent with custody of the child
3. third, if the parent with custody of the child is remarried, the plan of the step-parent
4. finally, the plan of the parent who does not have custody of the child

(e) The plan that covers a person as an active employee (that is, someone who is not laid off or retired) determines benefits for that person and his or her dependents before the plan that covers that same person as a retiree.

This is called the *"active before retiree rule*." However, if the other plan's rule is based on length of coverage, and, if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.

If none of the above rules can be applied when trying to determine the order of coverage, the plan that has covered the person longer determines benefits before the plan that has covered that same person for the shorter period of time.

Your Claims

Right To Receive and Release Information

In order to fulfill the terms of this COB provision or any other provision of similar purpose:

- a claimant must provide the Plan with all necessary information
- the Plan may obtain from or release information to any other person or entity

Facility of Payment

A payment made under another plan may include an amount that should have been paid under the Community Choice Plan. If it does, the Community Choice Plan may pay that amount to the organization that made the payment. That amount will be treated as if it were a benefit payable under the Plan. The Community Choice Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of payments made by the Community Choice Plan is more than it should have been under the COB provision, the Plan may recover the excess from one or more of the following:

- the persons it has paid or for whom it has paid
- insurance companies, or
- other organizations

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

Provision for Persons Enrolled in Medicare Parts A and/or B

Special Provisions Applicable to Senior Employees and Senior Dependents Eligible for Medicare

A senior employee is an **active** employee age 65 or over who is eligible for medical coverage under the Community Choice Plan. A senior dependent is the spouse, age 65 or older, of an active employee who qualifies as a dependent of the employee.

Senior employees and senior dependents may continue medical coverage under the Community Choice Plan regardless of their eligibility for, or participation in, Medicare.

You may elect to terminate your medical coverage under the Community Choice Plan by notifying the GIC in writing that you do not want to continue this medical coverage.

Medical Coverage Primary to Medicare Coverage for the Disabled

A disabled employee is an employee covered under the Community Choice Plan who is under age 65 and who is entitled to Medicare disability for reasons other than End Stage Renal Disease. A disabled dependent is a dependent who is under age 65 and who is entitled to Medicare disability benefits for reasons other than End Stage Renal Disease.

Disabled employees and disabled dependents may continue their medical coverage under the Community Choice Plan, regardless of their eligibility or participation in Medicare.

Health Coverage Primary to Medicare Coverage for Covered Persons Who Have End Stage Renal Disease

For all covered persons with end stage renal disease (ESRD), coverage under the Plan will be primary to Medicare during the Medicare ESRD waiting period and the Medicare ESRD coordination period.

"End Stage Renal Disease" means that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life.

"Medicare ESRD Waiting Period" is generally the first three months after starting dialysis. You are not entitled to Medicare until after the three-month waiting period. This waiting period can be waived or shortened if a member participates in a self-dialysis training program or is scheduled for an early kidney transplant, respectively.

"Medicare ESRD Coordination Period" is 30 months long and occurs **after** the ESRD waiting period. The ESRD coordination period begins on the date that Medicare became effective **or would have become effective on the basis of ESRD.**

During that 30-month period, the Community Choice Plan, for the purpose of the COB provision, is the primary payer and Medicare is the secondary payer. After the 30 months, Medicare becomes the primary payer while the Plan becomes the secondary payer.

Appeal Rights

You have the right to appeal a benefit determination made by the Community Choice Plan within 60 days of the notification of the determination. Your appeal should state why you believe the final determination was in conflict with the Plan provisions. You should also include all supporting documentation (at your own expense) that you or your health care provider believes supports your position. The Plan will conduct a review of the submitted documentation, and a decision will be made within 30 days after receipt of your written request. The results of the appeal review will be sent to you in writing. The letter will contain the specific reasons for the Plan's decision and, if applicable, instructions as to any additional appeal procedures that may be available.

Appeals relating to the Managed Care Review Program (inpatient hospital admissions; certain outpatient diagnostic and surgical procedures; durable medical equipment; home health care; physical and occupational therapy; and chiropractic and osteopathic manipulation) should be directed to:

Commonwealth Indemnity Plan
Community Choice
Appeals Review
P.O. Box 2011
Andover, MA 01810-0035

All other appeals should be directed to:

Commonwealth Indemnity Plan
Community Choice
Appeals Review
P.O. Box 2075
Andover, MA 01810-0037

Request and Release of Medical Information

The Plan's policies for releasing and requesting medical information comply with the Health Insurance Portability and Accountability Act (HIPAA). For more details, refer to the Member Confidentiality Statement located in Appendix A at the back of this handbook.

Managed Care Program

Overview

The Managed Care Program under the Community Choice Plan includes the following three components:

1. Utilization Management
2. Medical Case Management
3. Quality Centers for Transplant Services and Specialized Procedures

The Managed Care Program determines the medical necessity and appropriateness of certain health care services by reviewing clinical information. This process, called Utilization Management, a standard component of most health care plans, ensures that benefits are paid appropriately for services that meet the Plan's definition of medical necessity. Managed Care Program staff will inform you in advance regarding what services will be covered. This program helps control costs while preserving the ability of the Group Insurance Commission to offer the benefits of an indemnity plan to enrollees.

Managed Care Program staff includes Patient Advocates who are registered nurses and other nurse reviewers working with physician advisors. To determine medical necessity, nurses speak with your physicians, hospital staff, and/or other health care providers to evaluate your clinical situation and the circumstances of your health care. A physician advisor on behalf of the Managed Care Program may speak with your physician to discuss the proposed treatment and/or the setting in which it will be provided.

The review process is initiated when you or someone on your behalf notifies a Member Care Specialist that:

- you or your dependent will be or has been admitted to the hospital, or
- a provider has recommended one of the procedures or services noted on the Notification Requirements charts on pages 19-21.

 You will also find the Plan's Notification Requirements on the Plan's web site at **www.unicare-cip.com**.

Important: **If your provider or you fail to notify the Commonwealth Service Center within the required time frame as specified in the Notification Requirements chart starting on page 19, your benefits may be reduced by as much as $500. The purpose of notifying the Plan is to give the Plan sufficient time to determine if the proposed service will be covered. This process minimizes your risk of incurring charges.**

☎ Managed Care Notification Requirements*

Treatment / Service	Notification Requirement
An Overnight Hospital Stay: Non-emergency Admission	At least 7 calendar days before the admission
Emergency Admission	Within 24 hours (next business day)
Maternity Admission	As soon as you know your expected due date or at least 7 days in advance of your admission **(you must also call again within one business day of being admitted to the hospital)**
Organ Transplants: Liver, Lung, Kidney, Heart, Bone Marrow, Kidney / Pancreas, All Other	At least 21 calendar days before transplant-related services begin
Durable Medical Equipment: (if the purchase price exceeds $500 or the expected rental charges will exceed $500 over the period of use)	At least one business day before ordering the equipment from the provider
Home Health Care Provided By: • Home Health Agencies • Visiting Nurse Associations • Home Infusion Therapy Companies • Private Duty Nurses	At least one business day before the services begin
Manipulative Therapy Provided By: • Chiropractors • Medical and Osteopathic Physicians	At least one business day before your first appointment date
Physical Therapy	At least one business day before your first appointment date
Occupational Therapy	At least one business day before your first appointment date

☎ To obtain the maximum level of benefits, you or your provider must notify a Member Care Specialist at 1-800-442-9300.

* Claims submission does not constitute notification.

Managed Care Program

☎ Managed Care Notification Requirements* (cont'd)

Treatment / Service	Notification Requirement
Selected Procedure Review: *(Some of these procedures may be performed in a doctor's office.)*	At least seven (7) calendar days before the procedure date for **non-emergency** procedures. If you are not sure whether or not your procedure is subject to these notification requirements, please call a Member Care Specialist at 1-800-442-9300.

Procedure	Definition
Cholecystectomy	Removal of the gallbladder by any method
Colonoscopy	Examination through a flexible telescopic tube (colonoscope) of the entire lower intestines (the large intestines or bowel)
CT Scans – Computerized Axial Tomography:	
• **Abdomen and/or Pelvis**	Special computerized x-ray of the abdomen or pelvis
• **Cervical Spine**	Special computerized x-ray of the neck
• **Thoracic Spine**	Special computerized x-ray of the middle back
• **Lumbosacral Spine**	Special computerized x-ray of the lower back
• **Thoracic Cavity**	Special computerized x-ray of the chest
Dilation and Curettage (D&C)	Stretching the cervix and removing or destroying the endometrial lining
Diskectomy of the Lumbosacral Spine	Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lower back
Hysterectomy	Removal of the uterus (through the abdomen or vagina) by any method
Hysteroscopy and/or Hysteroscopic Endometrial Ablation	Examination through a telescopic tube (hysteroscope) of the inside of the uterus for diagnosis and/or treatment such as removal or destruction of the endometrial lining or lesions such as fibroids or polyps

☎ To obtain the maximum level of benefits, you or your provider must notify a Member Care Specialist at 1-800-442-9300.

* Claims submission does not constitute notification.

☎ Managed Care Notification Requirements* (cont'd)

Procedure	Definition
Laminectomy/Laminotomy of the Lumbosacral Spine	Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lumbosacral spine (lower back)
MRI – Magnetic Resonance Imaging:	
• Abdomen and/or Pelvis	Imaging study of the abdomen or pelvis
• Cervical Spine	Imaging study of the neck
• Thoracic Spine	Imaging study of the middle back
• Lumbosacral Spine	Imaging study of the lower back
• Thoracic Cavity	Imaging study of the chest
Pelvic Laparoscopy	Examination through a telescopic tube (laparoscope) of the inside of the pelvis (the lower abdominal area) for diagnosis and/or treatment, aspiration, removal or destruction of abnormalities of the ovaries, fallopian tubes, uterus, female pelvic organs or surrounding structures
Sinus Surgery	Any procedure by any method that opens, removes or treats the nasal sinuses
Spinal Fusion of the Lumbosacral Spine	Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lumbosacral spine (lower back)
Spinal Instrumentation of the Lumbosacral Spine	Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lumbosacral spine (lower back)
UGI Endoscopy	Examination through a flexible telescopic tube (endoscope) of the upper gastrointestinal (UGI) area (that is, the esophagus, stomach, and duodenum) for diagnosis and/or treatment

☎ To obtain the maximum level of benefits, you or your provider must notify a Member Care Specialist at 1-800-442-9300.

* Claims submission does not constitute notification.

Managed Care Program

Utilization Management Program

Inpatient Hospitalizations

Initial Review: The Plan must review and determine the medical necessity of all inpatient hospital admissions. You or someone on your behalf must initiate this process by calling a Member Care Specialist at least seven (7) days in advance of a non-emergency admission, and within 24 hours or the next business day of an emergency admission.

The purpose of this process is to inform you prior to a non-emergency admission, or as soon as possible after an emergency admission, whether the admission will be considered for benefits under the Plan. In doing so, you minimize your risk of incurring charges for non-covered services.

Upon notification, a Patient Advocate will contact your physician to discuss the medical necessity and appropriateness of the treatment plan and setting.

You and your physician will each receive a notice in the mail telling you if the Plan has confirmed the medical necessity and appropriateness of the admission. This notice will also specify the initial length of stay approved for the admission.

If the Patient Advocate is unable to confirm the medical necessity and appropriateness of the treatment, the inpatient hospital setting or the anticipated length of stay, a physician advisor will speak with your physician before the Plan makes a final decision. If the Plan determines that the admission is not medically necessary and appropriate, the Patient Advocate will promptly notify you, your physician and the hospital.

***Continued Stay Review*:** Your physician may recommend that you stay in the hospital beyond the initial number of days that the Plan has approved. In this case, the Plan will determine whether or not a continued hospital stay is medically necessary and appropriate. You do not have to contact the Plan. The Patient Advocate will stay in touch with your physician while you are in the hospital and work with the hospital staff to facilitate planning for care that may be required after your discharge.

If the Patient Advocate is unable to confirm that the continued hospitalization is medically necessary, a physician advisor will speak with your physician before the Plan makes a final decision. If the Plan determines that the continued stay is not medically necessary and appropriate, the Patient Advocate will promptly notify you, your physician and the hospital.

Durable Medical Equipment Over $500

Any durable medical equipment (DME) ordered by a physician that is expected to cost more than $500 is subject to Plan review. The $500 may be the result of either the purchase price or the total rental charges.

The Plan must be notified at least one (1) business day before the equipment is ordered from the equipment provider. Upon notification, a Patient Advocate will contact your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the equipment. A Patient Advocate will notify you regarding whether the Plan will authorize coverage for the equipment.

If you obtain equipment through a Preferred Vendor, the authorized item will be covered at 100% of the allowed amount. Please note that if a covered item is not available through a Preferred Vendor and you obtain it from another provider, it will only be covered at 80% of the allowed amount.

Home Health Care
When a physician prescribes home health care services, the Plan must be notified at least one (1) business day before the services begin. Upon notification, a Patient Advocate will call your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the home health care services. A Patient Advocate will notify you whether the Plan will authorize coverage for the services.

Manipulative Therapy
Manipulative therapy refers to any hands-on treatment provided by a chiropractor or a medical or osteopathic physician. The Plan must be notified at least one (1) business day before the services begin. Upon notification, a Patient Advocate will call your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the manipulative therapy services.

Physical Therapy
When a physician prescribes physical therapy services for you or your dependent, the Plan must be notified one (1) business day before the date of your first appointment. A Patient Advocate will contact your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the physical therapy services.

Physical therapy must be ordered by a physician, and a copy of the order must be made available to the Plan upon request.

Occupational Therapy
When a physician prescribes occupational therapy services for you or your dependent, the Plan must be notified one (1) business day before the date of your first appointment. A Patient Advocate will contact your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the occupational therapy services.

Occupational therapy must be ordered by a physician, and a copy of the order must be made available to the Plan upon request.

Maternity Stays
The Plan covers hospital stays for childbirth as follows:

- 48 hours for normal deliveries
- 96 hours for cesarean sections

or as medically necessary. You must notify the Plan as soon as you know your expected due date or at least seven (7) days in advance of your admission. You must notify the Plan again within one (1) business day of being admitted to the hospital. Please call a Member Care Specialist if you have any questions.

Selected Procedures
Members scheduled on a non-emergency basis for one of the selected procedures listed on pages 20-21 must notify the Plan at least seven (7) calendar days before the scheduled date of the procedure. The Plan requires notification, whether the procedure is being done in a hospital on an inpatient or outpatient basis; in a free-standing facility; or in a physician's office. If you are scheduled to have a procedure or special test done and you do not know the medical term for it, ask your physician to call the Commonwealth Service Center to find out if prior notification is needed. Upon notification, a Patient Advocate will contact your physician to obtain clinical information that will be used to determine the medical necessity of the planned procedure and the appropriateness of the setting in which it will be provided.

If the Patient Advocate is unable to confirm the medical necessity and appropriateness of the planned procedure, a physician advisor will talk to your physician before a final decision is made. This decision will be communicated to you and your physician.

Managed Care Program

Appeals Process

If an initial denial occurs before or while health care services are being provided, and the attending physician or patient believes that the determination warrants an immediate reconsideration, either party may request reconsideration of that determination over the telephone on an expedited basis.

For an immediate reconsideration, the Commonwealth Service Center must receive requests and all supporting information within three (3) business days of the initial notification of denial. The reconsideration will be completed within two (2) business days of receipt of all necessary supporting documentation. The decision is then communicated verbally and in writing to the patient and the patient's health care provider.

If the denial is upheld, the patient can take the next step and appeal the decision to:

Commonwealth Indemnity Plan
Community Choice
Appeals Review
P.O. Box 2011
Andover, MA 01810-0035

Medical Case Management

The Medical Case Management Program facilitates the timely provision of appropriate, cost-effective, quality health care services that are tailored to meet an individual's health care needs. A medical case manager is a registered nurse with expertise to assist you and your family when you are faced with a serious medical problem such as stroke, cancer, spinal cord injury or other conditions that require multiple medical services. The medical case manager will:

- help you and your family cope with the stress associated with an illness or injury by facilitating discussions about health care planning, and enhance the coordination of services among multiple providers
- work with the attending physician and other involved health care providers to evaluate the present and future health care needs of the patient
- provide valuable information regarding available resources for the patient
- work with the mental health/substance abuse benefits administrator when you or your dependent's condition requires both medical and mental health services, to coordinate services and maximize your benefits under the Plan
- explore alternative funding sources or other resources in cases where medical necessity exists but there is a limit to coverage under the Plan
- facilitate the management of chronic disease states by promoting education, wellness programs, self help and prevention
- promote the development of an appropriate plan of care to ease the transition from a stay in a facility to the return home

Quality Centers and Designated Hospitals for Transplants

The Plan has designated certain hospitals as Quality Centers for organ transplants. These hospitals were chosen for their specialized programs, experience, reputation and ability to provide high quality care. The purpose of this program is to facilitate the provision of timely, cost-effective, quality services to eligible Plan enrollees and their dependents at specialized facilities. A medical case manager is available to support the patient and family before the transplant procedure and throughout the recovery period. The medical case manager will:

- assess the patient's ongoing needs
- coordinate services while the patient is awaiting a transplant

- help the patient and family to optimize Plan benefits
- maintain communication with the transplant team
- facilitate transportation and housing arrangements, if needed
- facilitate discharge planning alternatives
- coordinate home care plans as necessary
- explore alternative funding sources or other resources in cases where there is need but there are limited benefits under the Plan

Although you and your covered dependents have the freedom to choose any health care provider for these procedures, you can maximize your benefits when you use one of these Quality Centers. You or someone on your behalf should notify the Plan as soon as your physician recommends a transplant evaluation.

Coronary Artery Disease Secondary Prevention Program

The Coronary Artery Disease Secondary Prevention Program, available through Medical Case Management, is designed to help you make the necessary lifestyle changes that can reduce your cardiac risk factors. It is available to members with a history of heart disease. You may call a Member Care Specialist to ask about your eligibility and available programs.

Other Health Management Resources

MedCall®

The Plan's MedCall program provides a 24-hour, toll-free number to access nurse counselors who can answer your questions about procedures or symptoms that you would like to discuss. Nurse counselors can provide information about appropriate care settings and help you prepare for a doctor's visit. They can also discuss your medications and any potential side effects. MedCall also serves as a referral source for local, state and national self-help agencies. To speak with a nurse counselor, call the MedCall toll-free number, 1-800-424-8814. You will need to provide the following Plan-specific code: 1002.

By calling the above number, you can also access MedCall's library of nearly 300 audio tapes to get automated information over the phone on many health related topics. To view the list of available audio tapes, log onto **www.unicare-cip.com**.

Healthcare Advisor™

The Healthcare Advisor is a research tool available on the Plan's web site, **www.unicare-cip.com**, that gives you easy access to comprehensive and reliable health care information to help you evaluate your health care options. The Healthcare Advisor provides you with the following:

- information about health conditions or surgical procedures
- questions to ask at doctors' visits
- help with selecting hospitals

You can also use this web site tool to find out what types of treatment and surgical options are available for specific conditions, along with non-surgical alternatives such as drug therapies or lifestyle changes. In addition, you can research which hospitals are most experienced in performing the procedure you need, along with each hospital's complication rate for that procedure.

To access the Healthcare Advisor, you will need to enter the following password when prompted: u2decide.

Managed Care Program

Healthwise Knowledgebase

This is a comprehensive online database of unbiased, up-to-date medical information. You can use this database to research medications, medical conditions, medical tests, treatment options and other medical topics. To access Healthwise, log onto **www.unicare-cip.com** and click on "Health Care Resources."

Information on Inpatient Hospital Safety

Learn what's being done to improve patient safety in hospitals and how this information may help you select a hospital. Find out the extent to which hospitals in your area have implemented safety initiatives developed by the Leapfrog Group for Patient Safety and how frequently they have performed certain procedures. The Leapfrog Group is a coalition of more than 145 private and public organizations – including the Group Insurance Commission – providing health care benefits nationwide. For information about the Leapfrog Group and its efforts, log onto **www.unicare-cip.com** and click on "Health Care Resources."

Online Health Assessment

Assessing your health is an important first step in taking responsibility for your own health and well-being. Our free online health assessment will help you identify health risks and suggest what preventive actions you can take to achieve and maintain optimum health.

Here's how to take the assessment:

1. Log onto **www.unicare-cip.com** and click on "Health Care Resources"; then click on "Online Health Assessment."
2. ***First-time Visitors:*** Click on the "New User" link. Complete the registration form, selecting "GIC, Group Insurance Commission" from the group drop down menu. In the User ID field, enter your GIC member ID number (found on your Commonwealth Indemnity Plan medical ID card). You can create your own password.

   Return Visitors: Enter your user ID and password.
3. Click on **"Personal Wellness Profile"** from the menu bar and complete the assessment.
4. Click **"Generate Report"** to submit your assessment. You will receive an online evaluation based on the information you submitted, with suggestions on ways you can improve your health.

Once you have registered, you can return to the site to finish a partially completed survey and review your answers and report.

A Summary of Your Medical Benefits

This section contains a summary of your medical benefits under the Community Choice Plan, as follows:

- the level of benefits coverage
- any coinsurance, copays, or deductibles you are responsible for paying in connection with a service or supply
- any limits on the maximum number of visits allowed per calendar year
- any maximum dollar amounts per calendar year that are associated with a service or supply

Important: **The information contained in this section is only a summary of your medical benefits. For complete details of your medical plan benefits coverage, please refer to the Description of Covered Services section of this handbook, which follows the Benefit Highlights section.**

Look for the **book symbol** 🕮 next to each service listed in Benefits Highlights for the corresponding page in the Description of Covered Services section or other sections where this benefit is more fully described.

The **telephone symbol** ☎ you see throughout this handbook lets you know that, to obtain the maximum level of benefits, you or your provider must call the Commonwealth Service Center at 1-800-442-9300. Failure to do so will result in a reduction in benefits of up to $500. However, you do not need to call the Plan if you are outside the continental United States (the contiguous 48 states).

The **computer symbol** 💻 that you see throughout this handbook indicates that information on the highlighted topic is available on the Plan's web site, **www.unicare-cip.com**.

Benefit Highlights

Summary of Covered Hospital-Based Services

	Community Choice Hospitals	Other Hospitals
☎ Inpatient Hospital Services in an Acute Medical or Surgical Facility		📖 Also see page 35
Semi-Private Room, ICU, CCU and Ancillary Services	100% after $200 quarterly deductible	100% after $750 deductible per admission ($200 deductible if admitted from emergency room)
Medically Necessary Private Room	100% for the first 90 days in a calendar year after the inpatient quarterly deductible; then 100% at the semi-private level	100% for the first 90 days in a calendar year after the per admission deductible; then 100% at the semi-private level
Inpatient Diagnostic Laboratory and Radiology Expenses	100%	100%
☎ Inpatient Hospital Services in an Acute Rehabilitation Facility		📖 Also see page 35
	100% after $200 quarterly deductible	100% after $200 quarterly deductible
☎ Select Complex Procedures/High-Risk Maternity Care **(See Appendix F for list of procedures and hospitals)**		📖 Also see pages 50-51
Select Complex Procedures and High-Risk Maternity Care	100% after $200 quarterly deductible at a Designated Hospital or Community Choice Hospital	100% after $750 deductible per admission

☎ To obtain the maximum level of benefits, you or your provider must call a Member Care Specialist at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

Summary of Covered Hospital Based Services

	Community Choice Hospitals	Other Hospitals
Other Inpatient Facilities		Also see page 35
• Sub-acute Care Hospital/Facility • Transitional Care Hospital/Facility • Long-term Care Hospital/Facility • Chronic Disease Hospital/Facility • Skilled Nursing Facility	80% up to a maximum benefit of $10,000 per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% up to a maximum benefit of $10,000 per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Outpatient Hospital Services		Also see page 36-42
Emergency Room Charge	100% after $50 copay per visit; copay waived if admitted	100% after $100 copay per visit; copay waived if admitted
Laboratory	100%	100% after $50 copay[1]
☎Radiology	100%	100% after $50 copay[1]
☎Surgery	100% after $75 quarterly deductible	100% after $250 deductible per occurrence
☎ Physical Therapy and ☎ Occupational Therapy	80%	80%
Speech Therapy (as described in the Description of Covered Services)	100% up to a maximum benefit of $2,000 per calendar year	100% up to a maximum benefit of $2,000 per calendar year
Chemotherapy	100%	100%
Other Outpatient Hospital Services	100%	100%

[1] If you receive both laboratory and x-ray services at a non-Community Choice hospital in the same day, you will only be responsible for one $50 copay.

☎ To obtain the maximum level of benefits, you or your provider must call a Member Care Specialist at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

Benefit Highlights

Summary of Covered Hospital Based Services

	Community Choice Hospitals	Other Hospitals
Coronary Artery Disease (CAD) Secondary Prevention Program		📖 Also see page 25
Designated Programs Available Though Medical Case Management	90%. The 10% coinsurance amount does not count toward the out-of-pocket maximum.	90%. The 10% coinsurance amount does not count toward the out-of-pocket maximum.
Other Programs	Not covered	Not covered

	Quality Centers and Designated Hospitals for Selected Transplant Services	Other Hospitals
☎ **Transplant Services**		📖 Also see page 42
	100% after $200 quarterly deductible, only if at a Quality Center or Designated Hospital for Selected Transplant Services	**At a Community Choice Hospital:** 80% after $200 quarterly deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum **At a non-Community Choice Hospital:** 80% after $750 deductible per admission. The 20% coinsurance amount does not count toward the out-of-pocket maximum

☎ To obtain the maximum level of benefits, you or your provider must call a Member Care Specialist at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

All services must be medically necessary and all charges will be subject to Reasonable and Customary Allowed Amount. If you have any questions, please call a Member Care Specialist at 1-800-442-9300.

Summary of Covered Non-Hospital Services

	All Providers
Physician Services 📖 Also see page 40	
Inpatient	100%
Emergency Room	100%
Office, Home or Outpatient Hospital	100% after $10 copay
☎ Surgery	100%
☎ Chiropractic Care	80% after $10 copay; maximum benefit of $40 per visit, 20 visits per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Preventive Care 📖 Also see pages 40-41	
Office Visits (refer to preventive care schedules on pages 40-41)	100% after $10 copay
Annual Gynecological Visits	100% after $10 copay
Immunizations	100%
Family Planning Services 📖 Also see page 38	
Office Visits and Procedures	100% after $10 copay
Laboratory Tests (non-hospital based) 📖 Also see page 40	
Preferred Vendors[1]	100%
Other Vendors	80%[2]. The 20% coinsurance amount does not count toward the out-of-pocket maximum.

1 Please call the Commonwealth Service Center at 1-800-442-9300 for the names of the Preferred Vendors, or visit our web site at www.unicare-cip.com.

2 Enrollees residing or traveling outside of New England will receive 100% of the Reasonable and Customary Allowed Amount for services obtained from any licensed diagnostic laboratory.

☎ To obtain the maximum level of benefits, you or your provider must call a Member Care Specialist at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

Benefit Highlights

Summary of Covered Non-Hospital Services

	All Providers
☎ Radiology (non-hospital based) 🕮 Also see page 41	
	100%
☎ Private Duty Nursing 🕮 Also see page 41	
Provided in a Home Setting Only	80% for a registered nurse up to a calendar year maximum benefit of $8,000. Of this $8,000, up to $4,000 may be for licensed practical nurse services if no registered nurse is available. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
☎ Home Health Care 🕮 Also see page 39	
Medicare Certified Home Health Agencies and Visiting Nurse Associations[1]	80%
☎ Home Infusion Therapy 🕮 Also see page 52	
Preferred Vendors[2]	100%
Other Vendors	80%. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Hospice 🕮 Also see page 42	
Medicare Certified Hospice	100%
Bereavement Counseling	80% up to a maximum benefit of $1,500 per family. The 20% coinsurance amount does not count toward the out-of-pocket maximum.

[1] A program is available to enhance the benefit for Home Health Care by using designated providers. Please call a Member Care Specialist at 1-800-442-9300 for more information.

[2] Please call a Member Care Specialist at 1-800-442-9300 for the names of the Preferred Vendors. 💻 You can also find this information on our web site at www.unicare-cip.com.

☎ To obtain the maximum level of benefits, you or your provider must call a Member Care Specialist at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

All services must be medically necessary and all charges will be subject to Reasonable and Customary Allowed Amount. If you have any questions, please call a Member Care Specialist at 1-800-442-9300.

Summary of Covered Non-Hospital Services

	All Providers
Early Intervention Services for Children Also see page 38	
Programs Approved by the Department of Public Health	80% up to a calendar year maximum benefit of $3,200 and a lifetime maximum benefit of $9,600. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
☎ Ambulance Also see page 36	
	100%
☎ Durable Medical Equipment Also see pages 43-44	
Preferred Vendors[1]	100%
Other Vendors	80%. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Hospital-Based Personal Emergency Response System (PERS) Also see page 43	
Installation	80% up to a maximum benefit of $50. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Rental Fee	80% up to a maximum benefit of $40 per month. The 20% coinsurance amount does not count toward the out-of-pocket maximum.

[1] Please call a Member Care Specialist at 1-800-442-9300 for the names of the Preferred Vendors. 💻 You can also find this information on our web site at www.unicare-cip.com.

☎ To obtain the maximum level of benefits, you or your provider must call a Member Care Specialist at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

Benefit Highlights

Summary of Covered Non-Hospital Services

	All Providers
Prostheses[1] 📖 Also see page 41	80%
Braces[2] 📖 Also see page 37	80%
Hearing Aids 📖 Also see page 38	100% of the first $500; then 80% of the next $1,500, up to a maximum of $1,700 every two years. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Eyeglasses / Contact Lenses 📖 Also see pages 47 & 49	80%. Limited to the initial set within six months following cataract surgery.
All Other Covered Medical Services 📖 Also see pages 36-42	80%

[1] Breast prostheses are covered at 100%.

[2] Orthopedic shoes(s) with attached brace is covered at 100%.

Prescription Drug Plan – Benefits Administered by Express Scripts
📖 See page 65. For more information, call 1-877-828-9744 (toll free).

Mental Health, Substance Abuse and Enrollee Assistance Programs – Benefits Insured by United Behavioral Health. 📖 See page 71. For more information, call 1-888-610-9039 (toll free).

All services must be medically necessary and all charges will be subject to Reasonable and Customary Allowed Amount. If you have any questions, please call a Member Care Specialist at 1-800-442-9300.

Description of Covered Services

The following pages contain descriptions of various covered services under the Community Choice Plan. Please refer to the Benefit Highlights section for information regarding benefit percentages, copays, coinsurance amounts, deductibles, out-of-pocket maximum amounts and durations of benefits that apply to these covered services. The Benefit Highlights section also shows you the difference in the level of coverage when you use Community Choice Hospitals versus non-Community Choice Hospitals.

☎ Inpatient Hospital Services

Charges for the following services qualify as covered hospital charges if the services are for a hospital stay.

1. Room and board provided to the patient
2. Anesthesia, radiology and pathology services
3. Hospital pre-admission testing if you or your covered dependent is scheduled to enter the same hospital where the tests are performed within seven (7) days after they are performed. If the hospital stay is cancelled or postponed after the tests are performed, the charges will still be covered as long as the physician presents a satisfactory medical explanation.
4. Medically necessary services and supplies charged by the hospital, except for special nursing or physician's services
5. Physical, occupational and speech therapy
6. Diagnostic and therapeutic services

Services at Other Inpatient Facilities

Other inpatient facilities include:

- Sub-acute Care Hospital/Facility
- Transitional Care Hospital/Facility
- Long-term Care Hospital/Facility
- Chronic Disease Hospital/Facility
- Skilled Nursing Facility

Covered charges for these facilities include the following services:

1. Room and board
2. Routine nursing care, but not including the services of a private-duty nurse or other private-duty attendant
3. Physical, occupational and speech therapy provided by the facility or by others under arrangements with the facility
4. Such drugs, biologicals, medical supplies, appliances and equipment as are ordinarily provided by the facility for the care and treatment of its patients
5. Medical social services
6. Diagnostic and therapeutic services furnished to patients of the facility by a hospital or any other health care provider
7. Other medically necessary services as are generally provided by such treatment facilities

Coverage in "Other Inpatient Facilities"

NOTE: To qualify for coverage in "Other Inpatient Facilities," the purpose of the care in these facilities must be the reasonable improvement in the patient's condition. A physician must certify that the patient needs and receives, at a minimum, skilled nursing or skilled rehabilitation services on a daily or intermittent basis. Continuing care for a patient who has not demonstrated reasonable clinical improvement is not covered.

☎ To obtain the maximum level of benefits, you or your provider must notify a Member Care Specialist at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

Description of Covered Services

Emergency Treatment for an Accident or Sudden/Serious Illness

An emergency is an illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity, including severe pain that in the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in serious jeopardy to physical and/or mental health; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; or, in the case of pregnancy, a threat to the safety of a member or her unborn child.

Massachusetts provides a 911 emergency response system throughout the state. If you are faced with an emergency, call 911. In other states, check with your local telephone company about emergency access numbers. Keep emergency numbers and the telephone numbers of your physicians in an easily accessible location.

☎ Surgical Services

The payment to a surgical provider for operative services includes the usual pre-operative, intra-operative and post-operative care.

Charges for the following services qualify as covered surgical charges:

1. Medically necessary surgical procedures when performed on an inpatient or outpatient basis (hospital, physician's office or surgical center)
2. Services of an assistant surgeon when:
   (a) medically necessary
   (b) the assistant surgeon is trained in a surgical specialty related to the procedure and is not a fellow, resident or intern in training, and
   (c) the assistant surgeon serves as the first assistant surgeon. (Second or third assistants are not covered.)
3. Reconstructive and restorative surgery, but limited to the following:
   (a) Reconstruction of defects resulting from surgical removal of an organ or body part for the treatment of cancer. Such restoration must be within five (5) years of the removal surgery.
   (b) Correction of a congenital birth defect that causes functional impairment for a minor dependent child
   (c) Breast reconstruction following a mastectomy
   (d) Reconstruction of the other breast to produce a symmetrical appearance after mastectomy
   (e) Coverage for prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas

Medical Services

Charges for the following services qualify as covered medical charges, but only if they do not qualify as covered hospital or surgical charges:

1. **Ambulance/Air Ambulance** – only in the event of an emergency and when medically necessary. Benefits are payable only for transportation to the nearest facility equipped to treat the condition. Transportation to or from medical appointments, including dialysis, is not a covered service.
2. **Anesthesia** and its administration
3. **Audiology Services** – expenses for the diagnosis of speech, hearing and language

☎ To obtain the maximum level of benefits, you or your provider must notify a Member Care Specialist at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

disorders are covered when provided by a licensed audiologist when the services are provided in a hospital, clinic or private office. Services provided in a school-based setting are not covered. The Plan does not cover services that a school system is obligated to provide under Chapter 766 in Massachusetts or under a similar law in other states.

4. **Braces** – replacement of such equipment is also covered when required due to pathological change or normal growth.

   Orthotics are covered when they meet the following criteria:

   (a) ordered by a physician

   (b) custom fabricated (molded and fitted) to the patient's body

   (c) for use by that patient only

   Also see Exclusions.

5. **Cardiac Rehabilitation Treatment** – provided by a cardiac rehabilitation program (see definition on page 50).

6. **Certified Nurse Midwife Services** – provided in the home or in a hospital.

7. **Circumcision** – when provided for newborns up to 30 days from birth.

8. **Crutches** – replacement of such equipment is covered when required due to pathological change or normal growth.

9. **Diabetes** – benefits will be paid for charges incurred by a covered person for medically necessary equipment, supplies and medications for the treatment of diabetes. Coverage will include outpatient self-management training and patient management, as well as nutritional therapy. Coverage will apply to services and supplies prescribed by a doctor for insulin dependent, insulin using, gestational and non-insulin using diabetes. The Community Choice Plan will provide benefits for these services and supplies when prescribed by a physician under the medical component of the Plan or under the prescription drug plan as indicated below.

   Diabetic drugs, insulin and the following diabetic supplies are covered under the prescription drug plan:

   (a) blood glucose monitors

   (b) test strips for glucose monitors

   (c) insulin

   (d) syringes and all injection aids

   (e) lancets and lancet devices

   (f) prescribed oral agents

   (g) glucose agents and glucagon kits

   (h) urine test strips

   The following diabetic supplies are covered under the medical component of the Plan:

   (a) blood glucose monitors, including voice synthesizers for blood glucose monitors for use by legally blind persons

   (b) test strips for glucose monitors

   (c) laboratory tests, including glycosylated hemoglobin (HbA1c) tests, urinary protein/microalbumin and lipid profiles

   (d) insulin pumps and all related supplies

   (e) insulin infusion devices

   (f) syringes and all injection aids

(g) lancets and lancet devices

(h) urine test strips

(i) insulin measurement and administration

(j) aids for the visually impaired

(k) podiatric appliances for the prevention of complications associated with diabetes

Diabetes Self-Management Training
Diabetes self-management training and patient management, including medical nutritional therapy, may be conducted individually or in a group, but must be provided by:

- an education program recognized by the American Diabetes Association, or
- a health care professional who is a diabetes educator certified by the National Certification Board for Diabetes Educators

Coverage will include all educational materials for such program. Benefits will be provided as follows:

(a) upon the initial diagnosis of diabetes

(b) when a significant change occurs in symptoms or conditions, requiring changes in self-management

(c) when refresher patient management is necessary, or

(d) when new medications or treatments are prescribed

As used in this provision, "patient management" means educational and training services furnished to a covered person with diabetes in an outpatient setting by a person or entity with experience in the treatment of diabetes. This will be in consultation with the doctor who is managing the patient's condition. The doctor must certify that the services are part of a comprehensive plan of care related to the patient's condition. In addition, the services must be needed to ensure therapy or compliance or to provide the patient with the necessary skills and knowledge involved in the successful management of the patient's condition.

10. **Early Intervention Services for Children** – coverage of medically necessary Early Intervention Services for children from birth until their third birthdays includes occupational therapy, physical therapy, speech therapy, nursing care, psychological counseling, and services provided by early intervention specialists or by licensed or certified health care providers working with an Early Intervention Services program approved by the Department of Public Health.

11. **Family Planning Services** – office visits and procedures for the purpose of contraception. Office visits include evaluations, consultations and follow-up care. Procedures include fitting for a diaphragm or cervical cap; the insertion, re-insertion, or removal of an IUD or Levonorgestrel (Norplant); and the injection of progesterone (Depo-Provera).

    FDA approved contraceptive drugs and devices are available through the prescription drug plan.

12. **Gynecological Visits** – annual gynecological examination, including Pap smear

13. **Hearing Aids** – when prescribed by a physician; replacement only when necessary due to pathological change or loss of the hearing aid

14. **Hearing Screenings** for newborns

15. ☎ **Home Health Care** – and skilled nursing services provided under a plan of care prescribed by a physician and delivered by a Medicare-certified Home Health Care agency. (Refer to definition of Home Health Care in Plan Definitions on page 52.)

    The following services are only covered if the covered individual is receiving approved part-time, intermittent skilled care furnished or supervised by a registered nurse or licensed physical therapist:

    (a) Part-time, intermittent home health aide services consisting of personal care of the patient and assistance with activities of daily living

    (b) Physical, occupational, speech and respiratory therapy by the appropriate licensed or certified therapist

    (c) Nutritional consultation by a registered dietitian

    (d) Medical social services provided by a licensed medical social worker

    (e) Durable medical equipment (DME) and supplies provided as a medically necessary component of a physician-approved home health services plan

    However, the following charges do not qualify as covered home health care charges:

    (a) Charges for custodial care or homemaking services

    (b) Services provided by you, a member of your family or any person who resides in your home. Your family consists of you, your spouse and your children, as well as brothers, sisters and parents of both you and your spouse.

16. **Infertility Treatment** – non-experimental infertility procedures including, but not limited to:

    (a) Artificial Insemination (AI,) also known as Inter-uterine Insemination (IUI)

    (b) In Vitro Fertilization and Embryo Placement (IVF-EP)

    (c) Gamete Intrafallopian Transfer (GIFT)

    (d) Zygote Intrafallopian Transfer (ZIFT)

    (e) Natural Ovulation Intravaginal Fertilization (NORIF)

    (f) Cryopreservation of eggs as a component of covered infertility treatment (costs associated with banking and/or storing inseminated eggs are reimbursable only upon the use of such eggs for covered fertility treatment)

    (g) Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any

    (h) Donor sperm or egg procurement and processing, to the extent such costs are not covered by the donor's insurer, if any

    (i) Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility

    In Vitro Fertilization and other associated infertility procedures, with the exception of artificial insemination, are limited to five (5) attempts (see definition of "Attempt" on page 50).

Description of Covered Services

Charges for the following services are not considered covered services:

(a) experimental infertility procedures

(b) surrogacy

(c) reversal of voluntary sterilization

(d) procedures for infertility not meeting the Plan's definition on page 53.

Facility fees will be considered as covered services by the Plan only from a licensed hospital or a licensed free-standing ambulatory surgical center.

17. **Laboratory tests** – must be ordered by a physician. In order to obtain 100% coverage for outpatient diagnostic laboratory services, you must use a preferred laboratory vendor.

18. ☎ **Manipulative Therapy** – chiropractic or osteopathic manipulation used to treat neuromuscular and/or musculoskeletal conditions on a short term basis when the potential for functional gain exists. These services are subject to review by the Plan to determine medical necessity.

19. ☎ **Occupational Therapy** – by a registered occupational therapist when ordered by a physician.

20. **Orthotics** – covered when they meet the following criteria:

(a) ordered by a physician

(b) custom fabricated (molded and fitted) to the patient's body

(c) for use by that patient only

Also see Exclusions.

21. ☎ **Oxygen** and its administration

22. ☎ **Physical Therapy** – physical therapy used to treat neuromuscular and/or musculoskeletal conditions on a short term basis when the potential for functional gain exists. The Plan only covers one-on-one therapies rendered by a registered physical therapist or certified physical therapy assistant (under the direction of a physical therapist) and when ordered by a physician. These services are subject to review by the Plan to determine medical necessity.

23. **Physician Services** – medically necessary services provided by a licensed physician acting within the scope of that license providing such services in the home, hospital, physician's office, or other medical facility. Charges by physicians for their availability in case their services may be needed are not covered services. The Plan only pays physicians for the actual delivery of medically necessary services. Telephone and e-mail consultations are not covered.

24. **Preventive Care Schedule:**

(a) **For children (up to age 19)** – The Plan covers preventive level office visits or physical examinations for children as follows:

- two examinations, including hearing screening, while the newborn is in the hospital
- every two months until 18 months of age, then
- every three months from 18 months of age until 3 years of age, then
- every 12 months from 3 years of age until 19 years of age

☎ To obtain the maximum level of benefits, you or your provider must notify a Member Care Specialist at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

(b) **For adults (age 19 and over)** – The Plan covers preventive or routine level office visits or physical examinations every 12 months.

(c) The following screening procedures and laboratory tests performed as a component of preventive care:

- hemoglobin
- urinalysis
- glaucoma testing
- flexible sigmoidoscopy (exam of the lower bowel)
- chemistry profile for the purpose of preventive screening includes the following:

  – complete blood count (CBC)
  – glucose
  – blood urea nitrogen (BUN)
  – creatinine
  – transferase alanine amino (SGPT)
  – transferase asparate amino (SGOT)
  – thyroid stimulating hormone (TSH)

(d) The following screening procedures and laboratory tests performed as indicated:

- blood cholesterol level (every five years)
- mammograms (once between the ages of 35 and 40: yearly after age 40)
- stool for occult blood (annually after age 50)

(e) Gynecological examination annually (every 12 months) for women, including Pap smear

(f) Immunizations

25. ☎ **Private Duty Nursing Care** – highly skilled nursing care needed continuously during a block of time (greater than two hours) provided by a registered nurse while you are confined to your home. Charges for a Licensed Practical Nurse (LPN) are provided as shown in the Benefit Highlights section. Private Duty Nursing Care must:

    (a) be medically necessary

    (b) provide skilled nursing services, and

    (c) be exclusive of all other home health care services

26. **Prostheses** – replacement of such equipment is also covered when required due to pathological change or normal growth.

27. **Radioactive Isotope Therapy**

28. **Radiotherapy**

29. **Routine Foot Care** – charges for medically necessary routine foot care are covered if accompanied by medical evidence documenting:

    - in the case of an ambulatory patient, an underlying condition causing vascular compromise, such as diabetes, or
    - in the case of a non-ambulatory patient, a condition that is likely to result in significant medical complications in the absence of such treatment.

30. **Speech-Language Pathology Services** – Expenses for the diagnosis and treatment of speech, hearing and language disorders are covered when provided by a licensed speech-language pathologist or audiologist when the services are provided in a hospital, clinic or private office. Services provided in a school-based setting are not covered.

    Covered speech-language pathology services include the following:

- the examination and remedial services for speech defects caused by physical disorders
- physiotherapy in speech rehabilitation following laryngectomy

The Plan does not cover the following:

- services that a school system is obligated to provide under Chapter 766 in Massachusetts or under a similar law in other states
- language therapy for learning disabilities such as dyslexia
- cognitive therapy or rehabilitation
- voice therapy

31. **X-Rays** and other radiological exams

☎ Transplant Services

Benefits are payable, subject to benefit maximums, deductibles and limitations, for necessary medical and surgical expenses incurred for the transplanting of a human organ. (To receive the maximum benefit, please refer to Quality Centers and Designated Hospitals for Transplant Services on pages 24-25 and 30.)

Human Organ Donor Services

Benefits are payable, subject to benefit maximums, deductibles and limitations, for necessary expenses incurred for delivery of a human organ (any part of the human body, excluding blood and blood plasma) and medical expenses incurred by a person in direct connection with the donation of a human organ.

Benefits are payable for any person who donates a human organ to a person covered under the Plan, whether or not the donor is a member of the Plan.

The Plan also covers expenses for human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish the suitability of a bone marrow transplant donor. Such expenses consist of testing for A, B or DR antigens, or any combination thereof, consistent with the guidelines, criteria, rules and regulations established by the Massachusetts Department of Public Health.

Hospice Care Services

Upon certification by a physician that the covered individual is terminally ill, benefits are payable for charges incurred for the covered hospice care services when the patient is enrolled in a Medicare-certified hospice program. The services must be furnished under a written plan of hospice care, established by a hospice and periodically reviewed by the medical director and interdisciplinary team of the hospice.

A person is considered to be terminally ill when given a medical prognosis of six (6) months or less to live.

List of Covered Hospice Care Services

The Plan covers the following hospice care services:

1. part-time, intermittent nursing care provided by or supervised by a registered nurse
2. physical, respiratory, occupational and speech therapy by an appropriate licensed or certified therapist
3. medical social services
4. part-time, intermittent services of a home health aide under the direction of a registered nurse
5. necessary medical supplies and medical appliances
6. drugs and medications prescribed by a physician and charged by the hospice
7. laboratory services
8. physicians' services

☎ To obtain the maximum level of benefits, you or your provider must notify the Commonwealth Service Center at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

9. Transportation needed to safely transport the terminally ill person to the place where that person is to receive a covered hospice care service

10. Psychological, social and spiritual counseling for the patient furnished by a:

    (a) physician
    (b) psychologist
    (c) member of the clergy
    (d) registered nurse, or
    (e) social worker

11. Dietary counseling furnished by a registered dietitian

12. Respite care

13. Bereavement counseling furnished to surviving members of a terminally ill person's immediate family or other persons specifically named by a terminally ill person. Bereavement counseling must be furnished within 12 months after the date of death and it must be furnished by a:

    (a) physician
    (b) psychologist
    (c) member of the clergy
    (d) registered nurse, or
    (e) social worker

    No hospice benefits are payable for services not included in the List of Covered Hospice Care Services, nor for any service furnished by a volunteer, or for which no charge is customarily made.

Hospital-Based Personal Emergency Response Systems (PERS)

Benefits are payable for the rental of a PERS if:

1. the service is provided by a hospital
2. the patient is homebound and at risk medically, and
3. the patient is alone at least four (4) hours a day, five (5) days a week, and is functionally impaired

No benefits are payable for the purchase of a PERS unit.

☎ Durable Medical Equipment (DME)

To meet the Plan's definition of DME, the service or supply must be:

1. provided by a DME supplier
2. designed primarily for therapeutic purposes or to improve physical function
3. provided in connection with the treatment of disease, injury or pregnancy upon the recommendation and approval of a physician
4. able to withstand repeated use, and
5. ordered by a physician

Benefits are payable if the DME service or supply meets the Plan's definition of DME and is determined to be medically necessary.

The Plan covers the rental of DME up to the purchase price. If the Plan determines that the purchase cost is less than the total expected rental charges, it may decide to purchase such equipment for your use. If you choose to continue to rent the equipment, the Plan will not cover rental charges that exceed the purchase price.

☎ To obtain the maximum level of benefits, you or your provider must notify the Commonwealth Service Center at 1-800-442-9300. See the Managed Care section for specific notification requirements and responsibilities.

Description of Covered Services

Excluded Items

No benefits are available for items such as, but not limited to, air conditioners, air purifiers, arch supports, bed pans, blood pressure monitors, commodes, corrective shoes, dehumidifiers, dentures, elevators, exercise equipment, heating pads, hot water bottles, humidifiers, shower chairs, whirlpools or spas. These items do not qualify as covered durable medical equipment.

Important: *Using Preferred Vendors will maximize your benefit by reducing your out-of-pocket cost. Call a Member Care Specialist at 1-800-442-9300 for a list of Preferred Vendors or find this information on www.unicare-cip.com.*

Coverage for Clinical Trials

Patient care services provided as part of a qualified clinical trial are covered to the same extent as they would be covered if the patient did not receive care in a qualified clinical trial. Coverage is subject to all other provisions of the Plan including, but not limited to, provisions relating to the use of participating providers and utilization review.

"Patient care service" means a health care item or service provided to an individual enrolled in a qualified clinical trial that is consistent with the patient's diagnosis, consistent with the study protocol for the clinical trial and would be covered if the patient were not a participant in a clinical trial. "Patient care service" does not include:

1. An investigational drug or device. However, a drug or device that has been approved for use in the qualified clinical trial will be a patient care service to the extent that the drug or device is not paid for by the manufacturer, distributor or provider of the drug or device, whether or not the Food and Drug Administration has approved the drug or device for use in treating the patient's particular condition.
2. Non-health care services that a patient may be required to receive as a result of participation in the clinical trial
3. Costs associated with managing the research of the clinical trial
4. Costs that would not be covered for non-investigational treatments
5. Any item, service or cost that is reimbursed or furnished by the sponsor of the clinical trial
6. The costs of services that are inconsistent with widely accepted and established national or regional standards of care
7. The costs of services that are provided primarily to meet the needs of the trial, including, but not limited to, tests, measurements and other services that are typically covered but are being provided at a greater frequency, intensity or duration
8. Services or costs that are not covered under the Plan

Exclusions

The Community Choice Plan does not provide benefits for the following services. Please note that charges that are excluded by the Plan do not count toward out-of-pocket maximums and deductible amounts.

1. A service or supply furnished without the recommendation and approval of a physician (that is, without an order)

2. A service or supply reviewed under the Managed Care Program and determined by the Plan not to be medically necessary

3. A service or supply that is determined by the Plan to be experimental or investigational; that is, inadequate or lacking in evidence as to its effectiveness, through the use of objective methods and study over a long enough period of time to be able to assess outcomes. The fact that a physician ordered it or that this treatment has been tried after others have failed does not make it medically necessary.

4. A service or supply that is not medically necessary for the care and treatment of an injury, disease or pregnancy, unless:

   (a) furnished by a hospital for routine care of a child during a hospital stay that begins with birth and while the child's mother is confined in the same hospital, or

   (b) furnished by a hospital or physician for covered preventive care, as described under Description of Covered Services on pages 40-41, or

   (c) such service or supply qualifies as a covered Hospice Care service (see page 42)

5. A service or supply furnished for an occupational injury or disease for which a person is entitled to benefits under a Workers' Compensation Law or similar law

6. A service or supply provided by you, a member of your family or by any person who resides in your home. Your family consists of you, your spouse and children, as well as brothers, sisters and parents of both you and your spouse.

7. Acupuncture and acupuncture related services

8. Arch supports

9. The amount by which a charge for blood is reduced by blood donations

10. Acne-related services, such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery, dermabrasion or other procedures to plane the skin. Benefits are provided for outpatient medical care to diagnose or treat the underlying condition identified as causing the acne.

11. Blood pressure cuff (sphygmomanometer)

12. Breast pumps

13. Chair cars/vans

14. Cognitive rehabilitation or therapy

15. Computer-assisted communication devices

16. Custodial care

17. Services related to surgery undertaken as the result of denture wear or to prepare for the fitting of new dentures

Exclusions

18. Dietary or nutritional counseling or services provided by a dietitian or nutritional counselor except as otherwise noted on pages 37 and 43

19. Drugs not used in accordance with indications approved by the Food and Drug Administration (off label use of a prescription drug), unless the use meets the definition of medically necessary as determined by the Plan or the drug is specifically designated as covered by the Plan

20. Over-the-counter drugs

21. Any services or supplies furnished by, or covered as a benefit under, a program of any government or its subdivisions or agencies except for the following:
    (a) a program established for its civilian employees
    (b) Medicare (Title XVIII of the Social Security Act)
    (c) Medicaid (any state medical assistance program under Title XIX of the Social Security Act)
    (d) a program of hospice care

22. Hearing aid batteries or ear molds

23. Hippotherapy

24. Experimental treatment for infertility

25. Incontinence supplies

26. Internet providers or e-mail consultations

27. Language therapy for learning disabilities such as dyslexia

28. Lift or riser chairs

29. Long-term maintenance care or long-term therapy

30. Certain manipulative therapy services, such as paraffin treatment; microwave, infrared and ultraviolet therapies; diathermy; massage therapy; acupuncture; aerobic exercise; rolfing therapy; Shiatsu; sports conditioning/weight training; or therapies performed in a group setting

31. Massage therapy or services provided by a massage therapist or neuromuscular therapist

32. A medical service or supply for which a charge would not have been made in the absence of medical insurance

33. Any medical services, including in vitro fertilization, in connection with the use of a gestational carrier or surrogate

34. Orthopedic/corrective shoe(s), except when the shoe(s) attaches directly to a brace

35. Orthopedic mattresses

36. Oxygen equipment required for use on an airplane or other means of travel

37. Personal comfort items that could be purchased without a prescription, such as air conditioners, air purifiers, bed pans, commodes, dehumidifiers, dentures, elevators, exercise equipment, heating pads, hot water bottles, humidifiers, telephones, shower chairs, televisions, whirlpools or spas and other similar items

38. Private duty nursing services in an acute care hospital or any other inpatient facility

39. Redundant or duplicate services. A service is considered redundant when same service(s) and supplies are being provided or being used, concurrently, to treat the condition for which it is ordered.

40. Reversal of voluntary sterilization

41. Sensory integration therapy

42. Any services and treatments required under law to be provided by the school system for a child

43. Sexual reassignment surgery and related services

44. Smoking cessation programs or medications

45. Stairway lifts and stair ramps

46. Storage of autologous blood donations or other bodily fluids or specimens, except when done in conjunction with use in a scheduled procedure that is covered under the Plan

47. Surface electromyography (SEMG)

48. Telephone consultations

49. Vision care, including:

    (a) eye examinations, surgery, services or supplies furnished in conjunction with the determination or correction of refractive errors such as astigmatism, myopia, hyperopia and presbyopia

    (b) the portion of an eye examination to determine if you need prescription lenses and the specifications for those lenses

    (c) orthoptics or visual therapy for correction of vision

    (d) radial keratotomy and related laser surgeries

50. Voice therapy

Limitations

The Community Choice Plan limits benefits for the following services and products:

1. **Ambulance** used for transportation services other than in the case of an emergency. Please see the definition of "Emergency" on page 52. Benefits are payable only for transportation to the nearest facility equipped to treat the condition. Transportation required for medical appointments, including dialysis treatment, is not covered.

2. **Air and sea ambulance services** are limited to the medically necessary transfer to the nearest facility equipped to treat the condition.

3. **Assistant surgeon services** are limited to the services of only one assistant surgeon per procedure when medically necessary. Second and third assistants are not covered.

   Non-physician assistants at surgery, such as physicians assistants (PAs), nurses and technicians are not covered. Interns, residents and fellows are also not covered. Chiropractors, dentists, optometrists and certified midwives are not covered as surgical assistants or as assistant surgeons.

4. **Bone density testing** is not covered when done solely for the purpose of screening.

5. **Cosmetic procedures/services** are not covered, with the exception of the initial surgical procedure to correct appearance that has been damaged by an accidental injury that occurred on or after the member's effective date of continuous health care coverage under any plan provided by the GIC. Only the first such surgery is covered.

6. **Dental benefits** are limited. The Community Choice Plan is a medical plan, not a dental plan. The Plan provides benefits for covered services relating to dental care or surgery in the following situations only:

   (a) Emergency treatment rendered by a dentist within 72 hours of an accidental injury to the mouth and natural sound teeth. This treatment is limited to the initial first aid (trauma care), reduction of swelling, pain relief, covered non-dental surgery and non-dental diagnostic x-rays.

   (b) Oral surgical procedures for non-dental medical treatment, such as the reduction of a dislocated or fractured jaw or facial bone, and removal or excision of benign or malignant tumors, are provided to the same extent as other covered surgical procedures described on page 56.

   (c) The following procedures when a member has a serious medical condition* that makes it essential that he or she be admitted to a hospital as an inpatient, or to a surgical day care unit or ambulatory surgical facility as an outpatient, in order for the dental care to be performed safely:

      (1) extraction of seven (7) or more teeth

      (2) gingivectomies (including osseous surgery) of two (2) or more gum quadrants

   ** Serious medical conditions include, but are not limited to, hemophilia and heart disease.*

(3) excision of radicular cysts involving the roots of three (3) or more teeth

(4) removal of one (1) or more impacted teeth

Facility, anesthesia and related charges are only covered when the dental treatment or services are covered under the Plan.

7. **Electrocardiogram (EKG)** is not covered when done solely for the purpose of screening or prevention.

8. **Eyeglasses/contact lenses** are limited to the provision, replacement or fitting for the initial set only when subsequent to an injury to the eye or up to six (6) months following cataract surgery.

9. **In Vitro Fertilization** and other associated infertility procedures, with the exception of artificial insemination, are limited to five (5) attempts (see definition of "Attempt" on page 50).

10. **Orthotics** are limited to medically necessary devices. Charges for test or temporary orthotics are not covered. Charges for video tape gait analysis and diagnostic scanning are not covered. Arch supports are also not covered.

11. **Routine screening** is not covered other than the Preventive Care Services specified in the Description of Covered Charges on pages 40-41.

12. **Treatment of Temporomandibular Joint (TMJ) disorder** is limited to the initial diagnostic examination and testing and medically necessary surgery.

13. **Weight loss programs** are limited to the treatment of morbid obesity (at least 100% overweight) while under the care of a physician. Any such program is subject to periodic review for medical necessity and progress.

14. **Wigs** are limited to the replacement of hair loss as a result of treatment of any form of cancer or leukemia. The maximum benefit for a wig is limited to $350 per calendar year.

Plan Definitions

Some terms used in the Community Choice Plan handbook are defined below as they relate to your benefits. Read these definitions carefully; they will help you understand what is covered under the Plan.

"Acute Care" – a level of care required as a result of the sudden onset or worsening of a condition that necessitates short term, intensive medical treatment. Acute inpatient care must be provided at a facility licensed as an acute care hospital. See definition for "Hospital."

"Ancillary Services" – the services and supplies that a facility ordinarily renders to its patients for diagnosis or treatment during the time the patient is in the facility. Ancillary Services include such things as:

1. use of special rooms, such as operating or treatment rooms
2. tests and exams
3. use of special equipment in the facility
4. drugs, medications, solutions, biological preparations and medical and surgical supplies used while inpatient in the facility
5. administration of infusions and transfusions. This does not include the cost of whole blood, packed red cells, or blood donor fees.
6. devices that are an integral part of a surgical procedure. This includes items such as hip joints, skull plates and pacemakers. It does not include devices that are not directly involved in the surgery, such as artificial limbs, artificial eyes or hearing aids.

"Assistant Surgeon" – a physician trained in the appropriate surgical specialty who serves as the first assistant to another surgeon during a surgical procedure. When medically appropriate, the service of only one assistant per procedure is covered under the Plan.

"Attempt" – the initiation of a reproductive cycle with the expectation of implanting a fertilized ovum. The occurrence of either of the following events constitutes an attempt:

- commencement of drug therapy to induce ovulation, or
- operative procedures for the purpose of implantation of a fertilized ovum

"Cardiac Rehabilitation Program" – a recognized, multi-disciplinary program operated by a licensed facility that treats cardiovascular disease through cardiac rehabilitation treatment. The program must meet the generally accepted standards of cardiac rehabilitation.

"Cardiac Rehabilitation Treatment" – treatment of documented cardiovascular disease by a cardiovascular rehabilitation program that includes exercise and diet management in order to improve cardiovascular function.

"Cognitive Rehabilitation or Cognitive Therapy" – treatment to restore function or minimize effects of cognitive deficits, including but not limited to those related to thinking, learning and memory.

"Community Choice Hospital" – a Massachusetts hospital designated by the Plan where certain services are covered by the Plan at the lower member deductibles and copays. Such services include inpatient admission and outpatient surgery, among others.

"Complex Procedures/High Risk Maternity Care" – Select inpatient surgical procedures designated by the Plan or high risk pregnancy care for which significant clinical experience is likely to enhance the quality of care. The Plan has also specified

certain hospitals that meet experience parameters in terms of patient volume for each of these procedures. For those procedures performed in the corresponding specified hospitals, services are covered at the lower member deductibles and copays.

"Coronary Artery Disease Secondary Prevention Program" – an approved established program for individuals with a diagnosis of coronary artery disease, offered by a specialized interdisciplinary team of clinicians, designed to reduce the effects of heart disease by lifestyle change, diet control, exercise, stress reduction and group support.

"Cosmetic Procedures/Services" – Cosmetic services are those services performed mainly for the purpose of improving appearance. These services do not restore bodily function or correct functional impairment. Cosmetic services are not covered, even if they are intended to improve a member's emotional outlook or treat a member's mental health condition.

"Custodial Care" – a level of care that is chiefly designed to assist a person in the activities of daily living and cannot reasonably be expected to greatly restore health or bodily function.

"Dependent" –

1. The legal spouse (or the former spouse if authorized by the GIC) of the covered employee or retiree
2. An unmarried child of a covered employee, retiree or surviving spouse by birth, legal adoption (upon placement of the child in the home), under custody pursuant to a court order, or under legal guardianship until the age of 19 years
3. An unmarried child who depends upon and lives with the covered employee, retiree or surviving spouse and for whom there is evidence of a regular parent-child relationship satisfactory to the GIC, until the age of 19 years
4. An unmarried child who upon becoming 19 years of age is mentally or physically incapable of earning his or her own living, proof of which must be on file with the GIC
5. A full-time student, as determined by the GIC, until the age of 24 years (at age 24, a full-time student may elect to continue coverage as an individual under the Community Choice Plan at 100% of the required premium. That student must file a written application with the GIC and the application must be approved by the GIC), or
6. A newborn child of a covered employee's, retiree's or surviving spouse's dependent son or daughter until the parent of such child ceases to be a dependent of such covered person, or the date the newborn child ceases to be a dependent, whichever occurs first.

"Designated Hospital" – A hospital designated by the Plan for which the benefits are covered at a higher level for certain services, specifically: complex procedures, high risk maternity care and transplants.

"Durable Medical Equipment" – equipment designed primarily for therapeutic purposes or to extend function that can stand repeated use and is medically necessary and prescribed by a physician. Such equipment includes wheelchairs, crutches, oxygen and respiratory equipment. Personal items related to activities of daily living such as commodes and shower chairs are not covered.

"Early Intervention Services" – medically necessary services that include occupational, physical and speech therapy, nursing care and psychological counseling for children from birth until their third birthdays. These services

must be provided by persons licensed or certified under Massachusetts law, who are working in Early Intervention programs approved by the Department of Public Health.

"Emergency" – An emergency is an illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity, including severe pain that in the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in serious jeopardy to physical and/or mental health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or, in the case of pregnancy, a threat to the safety of a member or her unborn child. Emergency treatment does not include Urgent Care. Emergency treatment may be rendered in a hospital, physician's office or other medical facility.

"Enteral Therapy" – prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines. Enteral formulas are not covered under the medical plan. Prescription and non-prescription enteral formulas are covered under the prescription drug plan only when ordered by a physician for the medically necessary treatment of malabsorption disorders caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

"Experimental or Investigational Procedures" – a service that is determined by the Plan to be experimental or investigational; that is, inadequate or lacking in evidence as to its effectiveness, through the use of objective methods and study over a long enough period of time to be able to assess outcomes. The fact that a physician ordered it or that this treatment has been tried after others have failed does not make it medically necessary.

"Family Planning Services" – office visits and procedures for the purpose of contraception. Procedures include fitting for a diaphragm or cervical cap; the insertion, re-insertion, or removal of an IUD or Levonorgestrel (Norplant); and the injection of progesterone (Depo-Provera). FDA-approved contraceptive drugs and devices are available through your prescription drug plan.

"Home Health Care" – health services and supplies provided by a home health care agency on a part-time, intermittent or visiting basis. Such services and supplies must be provided in a person's place of residence (not an institution) while the person is confined as a result of injury, disease or pregnancy. To be considered for coverage, Home Health Care must be delivered by a Home Health Care Agency certified by Medicare.

"Home Health Care Plan" – a plan of care for services in the home ordered in writing by a physician. A Home Health Care Plan is subject to review and approval by the Plan.

"Home Infusion Company" – a company that is licensed as a pharmacy and is qualified to provide home infusion therapy.

"Home Infusion Therapy" – the administration of intravenous, subcutaneous or intramuscular therapies provided in the home setting. Subcutaneous and intramuscular drugs are available through your prescription drug plan.

"Hospice" – a public agency or a private organization that provides care and services for terminally ill persons and their families and is certified as such by Medicare.

"Hospital" – an institution that meets all of the following conditions:

1. is operated pursuant to law for the provision of medical care
2. provides continuous 24-hour-a-day nursing care
3. has facilities for diagnosis
4. has facilities for major surgery
5. provides acute medical/surgical care or acute rehabilitation or care
6. is licensed as an acute hospital, and
7. has an average length of stay of less than 25 days

The term "Hospital" includes free-standing ambulatory surgical centers operating pursuant to law.

The term "Hospital" does not include:

(a) rest homes
(b) nursing homes
(c) convalescent homes
(d) places for custodial care
(e) homes for the aged

Also see definitions for **"Community Choice Hospitals"** and **"Other Inpatient Facilities."**

"Hospital Stay" – the time a person is confined to a hospital and incurs a room and board charge for inpatient care other than custodial care.

"Incurred Date" – the date a service or supply is provided.

"Infertility" – the condition of a healthy individual who is unable to conceive or produce conception during a period of one year, except if this condition is the result of voluntary sterilization or the normally occurring aging process.

"Injury" – bodily injury sustained accidentally by external means.

"Manipulative Therapy" – hands-on treatment provided by a chiropractor or osteopathic physician by means of direct manipulation, exercise, movement or other physical modalities applied to the body to relieve pain, restore function and/or minimize disability as a result of disease or injury to the neuromuscular and/or musculoskeletal system or following the loss of a body part. Acupuncture, aerobic exercise, rolfing therapy, Shiatsu, sports conditioning/weight training, group therapy, and other such treatments are not covered services.

"Medically Necessary" – with respect to care under the Plan, means that the treatment will meet at least the following standards:

1. is adequate and essential for evaluation or treatment consistent with the symptoms, proper diagnosis and treatment appropriate for the specific member's illness, disease or condition as defined by standard diagnostic nomenclatures (DSM-IV or its equivalent ICD-9CM)
2. is reasonably expected to improve or palliate the member's illness, condition or level of functioning
3. is safe and effective according to nationally accepted standard clinical evidence generally recognized by medical professionals and peer reviewed publications
4. is the most appropriate and cost-effective level that can safely be provided for the specific member's diagnosed condition, and
5. is based on scientific evidence for services and interventions that are not in widespread use

Plan Definitions

"Medical Supplies or Equipment" – disposable items prescribed by physicians as medically necessary to treat disease and injury. Such items include surgical dressings, splints and braces.

"Member Care Specialist" – a specially trained customer service representative who assists members by: responding to health plan questions and concerns; identifying and choosing appropriate health care providers; and providing guidance to health care resources and support.

"Non-Experimental Infertility Procedure" – a procedure recognized as generally accepted and/or non-experimental by the American Fertility Society and the American College of Obstetrics and Gynecology.

"Nursing Home" – an institution that:

1. provides inpatient skilled nursing care and related services, and
2. is licensed in any jurisdiction requiring such licensing, but
3. does not qualify as a Skilled Nursing Facility (SNF) as defined by Medicare

A home, facility or part of a facility does not qualify as a SNF or nursing home if it is used primarily for:

1. rest
2. the care of drug abuse or alcoholism
3. the care of mental diseases or disorders
4. custodial or educational care

"Occupational Injury/Disease" – an injury or disease that arises out of and in the course of employment for wage or profit (see Exclusions on page 45).

"Occupational Therapy" – Occupational therapy is skilled treatment that helps individuals achieve independence with activities of daily living after an illness or injury not incurred during the course of employment. Services include: treatment programs aimed at improving the ability to carry out activities of daily living; comprehensive evaluations of the home; and recommendations and training in the use of adaptive equipment to replace lost function.

"Off Label Use of a Prescription Drug" – the use of a drug that does not meet the prescribed indications as approved by the Food and Drug Administration (FDA).

"Orthotic" – an orthopedic appliance or apparatus used to support, align or correct deformities and/or to improve the function of movable parts of the body. An orthotic must be ordered by a physician, be custom fabricated (molded and fitted) to the patient's body, and be for use by that patient only.

"Other Inpatient Facilities" – includes the following hospitals/facilities:

1. skilled nursing facilities
2. chronic disease hospitals/facilities
3. transitional care hospitals/facilities
4. sub-acute care hospitals/facilities
5. long-term care hospitals/facilities
6. any inpatient facility with an average length of stay greater than 25 days

"Physician" – the term "physician" includes the following health care providers acting within the scope of their licenses or certifications:

1. physician
2. podiatrist
3. chiropractor
4. certified nurse midwife
5. dentist
6. optometrist

"Preferred Vendor" – a provider contracted by the Plan to provide certain services or equipment, such as lab services or durable medical equipment. When you use Preferred Vendors you receive these services at a

higher benefit level than when you use other providers for these services.

"Prostheses" – items that replace all or part of a bodily organ or limb and which are medically necessary and are prescribed by a physician. Examples include breast prostheses and artificial limbs.

"Reasonable and Customary Allowed Amount" – The Reasonable and Customary Allowed Amount (also referred to as the allowed amount) is the amount UniCare determines to be within the range of payments most often made to similar providers for the same service or supply. This payment may not be the same as the provider's actual charge. These allowed amounts are expressed as maximum fees in fee schedules, maximum daily rates, flat amounts or discounts from charges.

"Reasonable and Customary Charge" – a charge that does not exceed the general level of charges being made by others in a given geographic area where the charge is incurred when furnishing like or similar treatment, services or supplies.

"Reconstructive and Restorative Surgery" – surgery intended to improve or restore bodily function or to correct a functional physical impairment that has been caused by one of the following:

- a congenital anomaly, or
- a previous surgical procedure or disease

Restoration of a bodily organ that is surgically removed during treatment of cancer must be performed within five (5) years of surgical removal.

"Respite Care" – services rendered to a hospice patient in order to relieve the family or primary care person from caregiving functions. Respite care is covered in the home, hospital or in a skilled nursing facility or nursing home and is limited to a total of five (5) days.

"Skilled Care" – medical services that can only be provided by a registered or certified professional health care provider.

"Skilled Nursing Facility (SNF)" – an institution that:

1. is operated pursuant to law
2. is licensed or accredited as a skilled nursing facility if the laws of the jurisdiction in which it is located provide for the licensing or the accreditation of a skilled nursing facility
3. is approved as a skilled nursing facility for payment of Medicare benefits or qualified to receive such approval, if requested
4. is primarily engaged in providing room and board and skilled nursing care under the supervision of a physician
5. provides continuous 24-hour-a-day skilled nursing care by or under the supervision of a registered nurse (RN), and
6. maintains a daily medical record of each patient

A home, facility or part of a facility does not qualify as a skilled nursing facility or nursing home if it is used primarily for:

1. rest
2. the care of mental diseases or disorders
3. the care of drug abuse or alcoholism, or
4. custodial or educational care

"Spouse" – the legal spouse of the covered employee or retiree.

Plan Definitions

"Surgical Procedure" – any of the following types of treatment:

1. a cutting procedure
2. suturing of a wound
3. treatment of a fracture
4. reduction of a dislocation
5. radiotherapy, excluding radioactive isotope therapy, if used in lieu of a cutting operation for removal of a tumor
6. electrocauterization
7. diagnostic and therapeutic endoscopic procedures
8. injection treatment of hemorrhoids and varicose veins, and
9. an operation by means of laser beam

"Temporomandibular Joint (TMJ) Disorder" – a syndrome or dysfunction of the joint between the jawbone and skull and the muscles, nerves and other tissues related to that joint.

"Urgent Care" – treatment that is provided as soon as the treatment can be arranged, but the treatment is not immediately necessary to prevent death or permanent impairment. Urgent Care does not qualify as emergency treatment.

"Visiting Nurse Association" – an agency, certified by Medicare, that provides part-time, intermittent skilled nursing services and other home care services in a person's place of residence and is licensed in any jurisdiction requiring such licensing.

"Written Proof" – satisfactory proof, in writing, of the incurral of a claim.

General Provisions

This section describes the enrollment process for you and your eligible dependents; when coverage begins and ends; and continuing coverage when eligibility status changes.

Application for Coverage

You must apply to the GIC for enrollment in the Plan. To obtain the appropriate forms, active employees should contact their GIC Coordinator, and retirees should contact the GIC.

To enroll newborns:
You must enroll that child within 31 days of the child's birth.

To enroll or add your dependents:
You must enroll each additional dependent when he or she becomes eligible. If you marry, you must enroll your spouse within 31 days of the marriage.

To enroll adopted children:
Adopted children must be enrolled within 31 days of placement in the home.

Full-time student coverage:
An unmarried dependent child who reaches age 19 is no longer eligible for coverage unless enrolled in an accredited school as a full-time student. In order to continue coverage for a full-time student, you must complete all of the following steps:

1. complete the initial written application sent to you by the Plan prior to the dependent's 19th birthday
2. complete subsequent verification forms sent to you by the Plan twice a year to verify continued full-time student status, and
3. return all the completed forms to the Commonwealth Service Center within 30 days of their receipt. If the forms are not received within 30 days, your dependent may have a gap in coverage.

If coverage for a student is interrupted for 24 or more consecutive months, the dependent is no longer eligible for coverage.

If you have questions about this process or need additional forms, please call 1-800-442-9300. You can also e-mail us from our web site at www.unicare-cip.com.

When Coverage Begins

Coverage under the Plan starts as follows:

For new employees:
Coverage begins on the first of the month following 60 days or two calendar months of employment, whichever is less.

For persons applying during an annual enrollment period:
Coverage begins on the following July 1.

For dependents:
Coverage begins on the later of:

1. the date your own coverage begins, or
2. the date the person qualifies as your dependent

For new retirees, spouses and surviving spouses:
You will be notified by the GIC of the date on which coverage begins.

Continued Coverage

Your eligibility for these benefits continues if you are:

1. an employee of the Commonwealth
2. a Commonwealth retiree who is not eligible for Medicare

3. a surviving spouse who is not eligible for Medicare
4. a retiree with Medicare who is not eligible for the Commonwealth Indemnity Medicare Extension Plan
5. a spouse of a Commonwealth retiree who is enrolled in Medicare Parts A and B but you are not eligible for Part A and B on your own right.

When Coverage Ends for Enrollees

Your coverage ends on the earliest of:

1. the end of the month covered by the last contribution toward the cost of your coverage
2. the end of the month in which you cease to be eligible for coverage
3. the date the enrollment period ends
4. the date of death, or
5. the date the Community Choice Plan terminates

When Coverage Ends for Dependents

A dependent's coverage ends on the earliest of:

1. the date your coverage under the Plan ends
2. the end of the month covered by your last contribution toward the cost of such coverage
3. the date you become ineligible to have dependents covered
4. the date the enrollment period ends
5. the date the dependent ceases to qualify as a dependent
6. the date the dependent begins active duty in the armed forces of the United States
7. the date the dependent marries
8. the date of the dependent's death
9. the date the Community Choice Plan terminates, or
10. the last day of the month in which the dependent turns age 19 unless he or she qualifies as a full-time student or handicapped dependent

Duplicate Coverage

No person can be covered by any other GIC health plan at the same time as:

1. an employee, retiree, surviving spouse, former spouse, or a dependent, or
2. a dependent of more than one covered person (employee, retiree, spouse or surviving spouse)

Special Enrollment Condition

If you have declined the Community Choice Plan for your spouse or for your dependents because they have other health coverage, you may be able to enroll them during the Plan year if the other coverage is lost. To obtain the appropriate enrollment forms:

- **Active enrollees:** check with your GIC Coordinator
- **Retirees:** contact the GIC in writing

Continuing Coverage

The following provisions in this section explain how coverage may be continued or converted if eligibility status changes.

Continuing Health Coverage Due to Involuntary Layoff

If you are no longer eligible for coverage due to involuntary layoff, you may have coverage under the Community Choice Plan continued for 39 consecutive weeks. This coverage would apply to you and all of your

dependents who are covered under the Community Choice Plan at the time you are laid off.

In the event of involuntary layoff, the person who has the option to continue coverage must:

1. elect the continuance, in writing, within 30 days after the date eligibility for coverage ends, and
2. pay the full cost of the coverage to the GIC

Coverage will end on the earliest of:

1. the end of the month of 39 consecutive weeks following the date you cease to be eligible for coverage
2. the end of the month covered by the last contribution toward the cost of your coverage
3. the date the coverage ends
4. the date the Community Choice Plan terminates, or
5. in the case of a dependent, the date that dependent would cease to qualify as a dependent if you had remained eligible for the coverage

Option to Continue Coverage As a Deferred Retiree

You are eligible for deferred retirement if you:

1. have 10 or more years of full-time service (as determined by the State Retirement Board or your retirement board), and
2. are eligible for a state pension, and
3. are leaving your retirement monies in your retirement system

The person who chooses to continue health coverage as a deferred retiree must:

1. contact the GIC for enrollment information, and
2. pay the full cost of the coverage to the GIC

Coverage will end on the earlier of:

1. the end of the month covered by the last contribution toward the cost of your coverage
2. the date the coverage ends
3. the date the Community Choice Plan terminates, or
4. in the case of a dependent, the date that dependent would cease to qualify as a dependent if you had remained eligible for the coverage
5. the date you withdraw your monies from the retirement system

Continuing Health Coverage for Survivors

In the event of your death, your surviving spouse may continue coverage for himself or herself and all dependents covered under the Community Choice Plan. If you have no surviving spouse, then your surviving dependent child or children may have such coverage continued until age 19.

In order to continue coverage, the person who has the option to continue coverage must:

1. elect the continuation in writing within 30 days after the date of your death, and
2. make the required contribution toward the cost of the coverage

Coverage for survivors will end on the earliest of these dates:

1. the end of the month in which the survivor dies
2. the end of the month covered by the last contribution payment for the coverage
3. the date the coverage ends

4. the date the Community Choice Plan terminates
5. in the case of a dependent, the date that dependent would cease to qualify as a dependent, or
6. the date the survivor remarries

Option to Continue Coverage After Change in Marital Status

Your spouse will not cease to qualify as a dependent solely because a judgment of divorce or of separate support is granted. If that judgment is granted while the former spouse is covered as a dependent and states that coverage for the former spouse will continue, that person will continue to qualify as a dependent under the Community Choice Plan, provided family coverage continues and neither party remarries.

If you get divorced, you must notify the GIC and send them a copy of your divorce decree. If you or your former spouse remarry, you must also notify the GIC.

The former spouse will no longer qualify as a dependent after the earliest of these dates:

1. the end of the period specified in the judgment during which that person must remain eligible for coverage
2. the end of the month covered by the last contribution toward the cost of the coverage
3. the date that person remarries
4. the date you remarry. If that person is still covered as a dependent on this date, and the judgment gives that person the right to continue coverage at full cost after you remarry, then that person may either elect to:
   (a) remain covered separately for the benefits for which he or she was covered on that date, or
   (b) enroll in COBRA, or
   (c) have a converted policy issued to provide those benefits

For the purposes of this provision "judgment" means only a judgment of absolute divorce or of separate support.

Group Health Continuation Coverage Under COBRA

This subsection contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

What Is COBRA Coverage?

COBRA, the Consolidated Omnibus Budget Reconciliation Act, is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called "Qualifying Events." If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This information explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617-727-2310, ext. 801, or write to the Public Information Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's web site at **www.dol.gov/ebsa**.

Who Is Eligible for COBRA Coverage?

Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an independent right to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts covered by the GIC's health benefits program, you have the right to choose COBRA coverage if:

- You lose your group health coverage because your hours of employment are reduced, or
- Your employment ends for reasons other than gross misconduct

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies
- Your spouse's employment with the Commonwealth ends for any reason other than gross misconduct or his/her hours of employment are reduced, or
- You and your spouse divorce or legally separate

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours of employment are reduced
- The parents divorce or legally separate, or
- The dependent ceases to be a dependent child (e.g., is over age 19 and is not a full-time student, or ceases to be a full-time student)

How Long Does COBRA Coverage Last?

By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a total of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce – occurs during the 18 months of COBRA coverage.

You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability**

determination within 60 days after you receive it and before your initial 18-month COBRA period ends in order to extend the coverage.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid **in full** when due (see section on paying for COBRA)
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability)
- The Commonwealth of Massachusetts no longer provides group health coverage to any of its employees, or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud)

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

How and When Do I Elect COBRA Coverage?

Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage.**

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

How Much Does COBRA Coverage Cost?

Under COBRA, you must pay 102 percent of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150 percent of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

How and When Do I Pay for COBRA Coverage?

If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period.** After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement.** Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

Can I Elect Other Health Coverage Besides COBRA?

Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance "conversion" policy with your current health plan without providing proof of insurability. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

Your COBRA Coverage Responsibilities

- **You must inform the GIC of any address changes to preserve your COBRA rights.**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above.** If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill.** If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
- The employee's job terminates or his/her hours are reduced
- The employee or former employee dies
- The employee divorces or legally separates
- The employee or employee's former spouse remarries
- A covered child ceases to be a dependent

- The Social Security Administration determines that the employee or a covered family member is disabled, or
- The Social Security Administration determines that the employee or a covered family member is no longer disabled

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

Conversion to Non-Group Health Coverage

Under certain circumstances, a person whose Community Choice coverage is ending has the privilege to convert to non-group health coverage provided by UniCare.

A certificate for this non-group health coverage issued by UniCare can be obtained if:

1. employment for coverage purposes ends, except due to retirement, or
2. status changes to one that is not eligible for continued coverage under the Community Choice Plan

You cannot obtain a certificate of coverage if you are otherwise eligible under Community Choice, or if your coverage terminated for failure to make a required contribution when due. In addition, no certificate of coverage will be issued in a state or country where UniCare is not licensed to issue it.

The certificate of coverage will cover you and your dependents who cease to be covered under Community Choice because your health coverage ends, and any child of yours born within 31 days after such coverage ends.

A certificate of coverage is also available to the following persons whose coverage under Community Choice ceases:

1. Your spouse and/or your dependents, if their coverage ceases because of your death
2. Your child, covering only that child, if that child ceases to be covered under Community Choice solely because the child no longer qualifies as your dependent
3. Your spouse and/or dependents if their coverage ceases because of a change in marital status

The following rules apply to the issuance of the certificate of coverage:

1. Written application and the first premium must be submitted within 31 days after the coverage under the Community Choice Plan ends.
2. The rules of UniCare for coverage available for conversion purposes at the time application for a certificate of coverage is received govern the certificate. Such rules include: the form of the certificate; its benefits; the individuals covered; the premium payable and all other terms and conditions of such certificate.
3. If delivery of the certificate is to be made outside of Massachusetts, it may be on such form as is offered in the state where such certificate is to be delivered.
4. The certificate of coverage will become effective on the day after coverage under Community Choice ends.
5. No evidence of insurability will be required.

UniCare will furnish details of converted coverage upon request.

Commonwealth Indemnity Plan
Administered by UNICARE

Prescription Drug Plan

Administered By:

EXPRESS SCRIPTS®

Description of Benefits

Prescription Drug Plan

Express Scripts is the pharmacy benefit manager for your prescription drug plan. If you have any questions about your prescription benefits, contact the Express Scripts Customer Service Call Center toll free at 1-877-828-9744 (TDD: 1-800-842-5754).

About Your Plan

Your prescription drug plan uses a three tier copayment design.

The three tier design maintains a broad choice of covered drugs for patients and their physicians to choose from, while providing an incentive to use medications that are safe, effective and less costly. Frequently there is more than one prescription drug that your physician could prescribe for a particular illness or condition. Talk with your physician about your options to determine the best choice for you.

Generics Preferred

If your physician prescribes a brand name drug for which an FDA-approved generic equivalent is available, you will be responsible for the full difference in price between the brand and the generic drug, plus the generic copay.

Step Therapy

In some cases, your Plan requires the use of less expensive first-line prescription drugs before the Plan will pay for more expensive second-line prescription drugs. First-line prescription drugs are safe and effective medications used for the treatment of a medical condition or disease. Your prior claims history will show if first-line prescription drugs have been used before, allowing the more expensive medication to be approved. If a first-line prescription drug has been used previously, and has proven to be ineffective, a more expensive second-line prescription drug may be used. In certain situations a member may be granted a prior authorization for a second-line prescription drug if specific medical criteria have been met without the trial of a first-line prescription drug.

Current examples of second-line prescription drugs requiring Step Therapy:

Accupril®, Aciphex®, Accolate®, Aceon®, Altace®, Arthrotec®, Atacand®, Avalide®, Avapro®, Bextra®, Celebrex®, Celexa®, Cozaar®, Diovan®, Elidel®, Enbrel®, Humira®, Kineret®, Lexxel®, Lexepro®, Lotrel®, Micardis®, Mobic®, Monopril®, Nexium®, Paxil®, Ponstel®, Prevacid®, Prilosec®, Protonix®, Protopic®, Singulair®, Strattera® Tevetan®, Uniretic®, Vioxx®, Zoloft® and Zyflo®.

This list may change during the plan year.

How to Use the Plan

Retail

- Bring your Express Scripts ID card and your prescription(s) to a participating Express Scripts pharmacy. Pharmacy locations are available by contacting the Express Scripts Customer Service Call Center toll free at 1-877-828-9744 (TDD: 1-800-842-5754) or through the Express Scripts web site at: www.express-scripts.com.

So that your pharmacist has all the necessary information to process a claim, please follow the steps outlined below:

- You (or your family member) should present your Express Scripts member ID Card to your pharmacist each time you fill or refill a prescription.
- If you do not have your ID Card, you can provide your pharmacist with the card-holder's Social Security or GIC ID number, and the group number which is GICA.

- The pharmacist will also be able to verify eligibility by contacting the Express Scripts Pharmacy Help Desk toll free at 1-800-824-0898 (TDD: 1-800-842-5754).

If the pharmacy you are currently using is not participating in the Express Scripts network, you will need to transfer your prescription to an Express Scripts participating pharmacy. To do so, simply contact your current pharmacy and request a prescription transfer.

Retail (In-Network) Copayments

Retail Pharmacy *up to 30 days supply*	Member Copay
Tier 1: Generic drug	$7.00
Tier 2: Preferred brand name drug	$20.00
Tier 3: Non-Preferred brand name drug	$40.00*

**Additional charges will apply if the drug has a generic equivalent*

Mail

For prescriptions that you will take over an extended period of time, Express Scripts' convenient mail order and Internet service provides substantial savings.

To Begin Using Mail Service

- Obtain a 90-day prescription from your physician. (Please insure you have a 30-day supply on hand.)
- Clearly write your full name, address and Social Security or GIC ID number on the original prescription.
- Complete the patient profile included with your ID Card packet. Patient profiles are also available by contacting the Express Scripts Customer Service Call Center toll free at 1-877-828-9744 (TDD: 1-800-842-5754).
- Mail the patient profile along with your original prescription, and appropriate copay, in the envelope included with the ID Card packet or available by contacting the Express Scripts Customer Service Call Center toll free at 1-877-828-9744 (TDD: 1-800-842-5754).

To Obtain Mail Service Refills

Mail service prescription(s) refills are available by mailing in the refill slip, which you will receive with your first Express Scripts order. Refills are also available by contacting the Express Scripts Customer Service Call Center toll free at 1-877-828-9744 (TDD: 1-800-842-5754) or through www.express-scripts.com.

Mail Service Copayments

Mail Order *up to 90 days supply*	Member Copay
Tier 1: Generic drug	$14.00
Tier 2: Preferred brand name drug	$40.00
Tier 3: Non-preferred brand name drug	$70.00*

**Additional charges will apply if the drug has a generic equivalent*

Prescription Drug Plan

Claim Forms

Retail purchase(s) out of the country or in-network purchases without the use of your ID Card are covered as follows:

Type of Claim	Reimbursement
Claims for prescriptions for enrollees who reside in a nursing home or live or travel outside the U.S. or Puerto Rico.	Claims will be reimbursed at the full cost submitted less the applicable copayment.
Claims for purchases at a participating (in-network) pharmacy without a drug card.	Claims incurred within 30 days of the enrollee's eligibility effective date will be covered at full cost minus the applicable copayment. *-or-* Claims incurred more than 30 days after the enrollee's eligibility effective date will be reimbursed at a discounted cost minus the applicable copayment.

Commonly Used Terms

Generic Drug

Generic drugs are drugs for which the patent has expired, allowing other manufacturers to produce and distribute the product under its chemical name. Generics are essentially a chemical copy of their brand-name equivalents. The color or shape may be different, but the active ingredients must be the same. The Express Scripts formulary contains only FDA-approved generic medications.

Brand Name Drug

The brand name is the trade name under which the product is advertised and sold, and is protected by patents so that it can only be produced by one manufacturer for 17 years. Once a patent expires, other companies may manufacture a generic equivalent, providing they follow stringent FDA regulations for safety.

Preferred Brand Name Drug

A preferred brand name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a carefully selected group of physicians and pharmacists for formulary inclusion based on its proven clinical and cost effectiveness.

Non-Preferred Brand Name Drug

A non-preferred brand name drug, or non-formulary drug, is a medication that has been reviewed by the same team of physicians and pharmacists who determined that an alternative drug that is clinically equivalent and more cost effective is available. These designations may change, as new clinical information becomes available.

Formulary

A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The formulary contains a wide range of generic and brand name preferred products that have been approved by the Food and Drug Administration (FDA). The formulary applies to medications that are dispensed in both the retail pharmacy and mail service settings. The formulary is developed and maintained by Express Scripts.

Off-Label Use of a Prescription Drug

The off-label use of a prescription drug is the use of a drug for reasons not approved by the FDA.

Participating Pharmacy

A participating pharmacy is a pharmacy in the Express Scripts nationwide network. All chains and most independently owned pharmacies participate.

Prescription Drug

A prescription drug is any medical substance, the label of which under the Federal Food, Drug, and Cosmetic Act, must bear the legend: "Caution Federal Law prohibits dispensing without a prescription." The term prescription drug includes allergy extracts and insulin.

Prior Authorization

Prior Authorization means proof of medical necessity is required before a prescription for certain drugs will be paid by the plan. The purpose of prior authorization is to prevent misuse and the off-label use of expensive and potentially dangerous drugs.

Drugs that currently require Prior Authorization:

- Aranesp®, Epogen®, Procrit®
- Weight Loss Medications
- Growth Hormones
- For members over the age of 35: Retin A®, Differin®, Axita®
- Prolastin®
- Botox®
- Lamisil®, Sporanox®
- Tazorac®, Regranex®
- Penlac®
- Amevive®
- Forteo®

This list may change during the plan year.

Drug Utilization Review Program

Each prescription drug purchased through this program is subject to utilization review. This process evaluates the prescribed drug to determine if any of the following conditions exist:

- Adverse drug-to-drug interaction with another drug purchased through the program;
- Duplicate prescriptions;
- Inappropriate dosage and quantity; or
- Early refill of a prescription.

If any of the above conditions exist, medical necessity must be determined before the prescription drug can be processed.

Exclusions and Limitations

Benefits exclude drugs for off-label use, unless medically necessary for the care and treatment of an injury, illness or pregnancy. Additional exclusions:

- Smoking cessation programs or medications
- Dental preparations
- Over-the-counter drugs (with the exception of diabetic supplies)
- Vitamins or minerals prescribed in the absence of a medical condition (with the exception of prenatal vitamins)

- Prescriptions for cosmetic purposes. Quantities of some medications may be limited. Current examples include Cialis®, Imitrex®, Lamisil®, Levitra®, Maxalt®, Prevacid®, Prilosec®, Relenza®, Sporanox®, Tamiflu®, Viagra® and Zomig®.

This list is subject to revision.

Only medications covered under your benefit plan are included.

Claims Inquiry

If you believe your claim was incorrectly denied or you have questions about a prescription, call Express Scripts Customer Service Call Center toll free at 1-877-828-9744. The TDD number is 1-800-842-5754.

Appeal Rights for Prior Authorization Denials

Denials of request for Prior Authorization may be appealed by having your physician send a letter explaining why the product is medically necessary for you. This letter should be sent to Express Scripts, Prior Authorization, PO Box 39842, Bloomington, MN 55439-0842. Submission of appeal is not a guarantee of coverage.

Health and Prescription Information

Health and prescription information about members and dependents is used by Express Scripts to administer your benefits. As part of the administration, Express Scripts may report health and prescription information to the administrator or sponsor of your benefit plan. Express Scripts also uses that information and prescription data gathered from claims nationwide for reporting and analysis without identifying individual patients.

Commonwealth Indemnity Plan
Administered by UNICARE

United Behavioral Health

Mental Health, Substance Abuse and Enrollee Assistance Programs

Description of Benefits

UNITED BEHAVIORAL HEALTH

PART I – How to Use This Plan

A Comprehensive Plan Designed with Your Well-Being in Mind

As a covered person under the Commonwealth Indemnity Plan Community Choice, you are automatically enrolled in the mental health and substance abuse benefits program as well as the Enrollee Assistance Program (EAP) administered by United Behavioral Health. These programs offer you easy access to a broad range of services – from assistance with day-to-day concerns (e.g., legal and financial consultations, workplace-related stress, child-care and elder-care referrals) to mental health and substance abuse needs, including assistance in a psychiatric emergency. By offering effective, goal-focused care delivered by a network of highly qualified providers, this program is designed to improve well-being and functioning as quickly as possible.

United Behavioral Health (UBH) is administering the benefits under this program on behalf of the insurer, United Healthcare Insurance Company.

Let Us Show You the Benefits

The following describes your mental health, substance abuse and EAP benefits under the UBH plan. Please read it carefully before you seek care to ensure that you receive maximum benefits. The chart on pages 80-81 provides a brief overview of your benefits; however, it is not a detailed description. The detailed description of your benefits is found in Part III on pages 82-85. Words in italics throughout this description are defined in the "Definitions" section in Part II on page 78.

This is the "Description of Benefits" for your Mental Health, Substance Abuse and Enrollee Assistance Programs. While it is a full description of the available benefits under this plan, it is not the "Evidence of Coverage" that UBH submits to the Massachusetts Division of Insurance (DOI). The "Evidence of Coverage" is the legal policy document that governs the plan that includes state and federal mandated language, required disclosures to the Office of Patient Protection, continuation of coverage provisions as directed by state and federal law, and other required plan disclosures. The full "Evidence of Coverage" is available in electronic form and can be downloaded from the UBH web site www.liveandworkwell.com (access code: 10910). If you would prefer a paper copy of this document please send a written request to UBH at the address provided on page 76 and you will be sent a copy, free of charge.

How to Ensure Maximum Benefits

In order to receive maximum benefits and reduce your out-of-pocket expenses, there are two important steps you need to remember:

Step 1: **Call UBH for *precertification* before you seek mental health, substance abuse or EAP services; and**

Step 2: **Use a provider or facility from the UBH network.**

UBH offers you a comprehensive network of resources and experienced providers from which to obtain mental health, substance abuse and EAP services. All UBH *network providers* have been reviewed by UBH for their ability to provide quality care. If you receive care from a provider or facility that is not part of the UBH network, your benefits will be lower than for network care. These reduced benefits are defined as out-of-network benefits. If you fail to call UBH to *precertify* your care, you may be charged a penalty and your benefits may be reduced.

In some cases, if you fail to *precertify* your care, no benefits will be paid. Please refer to Part III, titled Benefits Explained, on page 82 for a full description of your network and out-of-network benefits, as well as special *precertification* requirements for certain out-of-network outpatient services. Benefits will be denied if your care is considered not to be a *covered service*.

Before You Use Your Benefits

Precertification

Precertification is the first step to obtaining your mental health, substance abuse and EAP benefits. To receive EAP services or before you begin mental health and substance abuse care, call UBH toll free at 1-888-610-9039 (TDD: 1-800-842-9489).

A trained *UBH clinician* will answer your call 24 hours a day, seven days a week, verify your coverage and refer you to a specialized EAP resource or a *network provider*. All *UBH clinicians* are experienced professionals with master's degrees in psychology, social work, or a related field. A *UBH clinician* will immediately be available to assist you with routine matters or in an emergency. If you have specific questions about your benefits or claims, call a customer service representative toll free from 9 a.m. to 8 p.m. Eastern Time to 1-888-610-9039 (TDD: 1-800-842-9489).*

Based on your specific needs, the *UBH clinician* will *precertify* visits if you are eligible for coverage at the time of your call, and provide you with the names of several mental health, substance abuse or EAP providers who match your request (e.g., provider location, gender, or fluency in a second language). UBH maintains an extensive database of information on every provider in the network. A directory of UBH providers can be found on the UBH web site, www.liveandworkwell.com (access code 10910). After *precertification*, you can then call the provider directly to schedule an appointment. **If you need assistance, a *UBH clinician* can help you in scheduling an appointment.** The *UBH clinician* can also provide you with a referral for legal, financial, or dependent care assistance or community resources, depending on your specific needs.

Emergency Care

Emergency care is required when a person needs immediate clinical attention because he or she presents a real and significant risk to him/herself or others. In a life-threatening emergency, you and/or your covered dependents should seek care immediately at the closest emergency facility. You, a family member or your provider must **call UBH within 24 hours** of an emergency admission to notify UBH of the admission. Although someone may call on your behalf, it is always the covered person's responsibility to ensure that UBH has been notified. If UBH is not notified of the admission, you will not be eligible for maximum benefits or benefits may be denied if it is not deemed to be a *covered service*. UBH staff is available 24 hours a day, seven days a week, to assist you and/or your covered family members.

Urgent Care

There may be times when a condition shows potential for becoming an emergency if not treated immediately. In such urgent situations, a UBH network provider will have an appointment to see you within 24 hours of your initial call to UBH. Call 1-888-610-9039 toll free (TDD: 1-800-842-9489) for assistance.

* As part of UBH's quality control program, supervisors monitor random calls to UBH's customer service department, but not the clinical department.

Routine Care

Routine care is for conditions that present no serious risk, and are not in danger of becoming an emergency. For routine care, *network providers* will have an appointment to see you within three (3) days of your initial call to UBH. Call 1-888-610-9039 toll free (TDD: 1-800-842-9489) for assistance.

Enrollee Assistance Program

Your Enrollee Assistance Program (EAP) benefit provides access to a range of resources, as well as focused, confidential, short-term counseling to treat problems of daily living (e.g., emotional, marital or family problems, legal disputes, or financial difficulties). The EAP benefit provides counseling and other professional services to you and your family members who are experiencing problems disrupting your personal and professional lives (e.g., reaction to international events, community trauma). The EAP can also provide critical incident response and on-site behavioral health-related consultations and seminars for state agencies.

Confidentiality

When you use your mental health, substance abuse and EAP benefits under this plan, you are consenting to the release of necessary clinical records to UBH for *case management* and benefit administration purposes. Information from your clinical records will be provided to UBH only to the minimum extent necessary to administer and manage the care provided when you use your EAP, mental health, and substance abuse benefits, and in accordance with state and federal laws. All of your records, correspondence, claims, and conversations with UBH staff are kept **completely confidential** in accordance with federal and state laws. No information may be released to your supervisor, employer, or your family without your written permission, and no one will be notified when you use your mental health, substance abuse and EAP benefits. UBH staff must comply with a strict confidentiality policy.

Complaints

If you are not satisfied with any aspect of the UBH program, we encourage you to call UBH toll free at 1-888-610-9039 (TDD: 1-800-842-9489) to speak with a customer service representative. The UBH customer service representative resolves most complaints during your initial call. Complaints that require further research are reviewed by representatives of the appropriate departments at UBH, including clinicians, claims representatives, administrators, and other management staff. We will respond to all complaints within three (3) business days. Your comments will help us correct any problems and provide better service to you and your dependents. If the resolution of your complaint is unsatisfactory to you, you have the right to file a formal complaint in writing within 60 days of the date of our telephone call or written response. Please specify dates of service and additional contact with UBH and include any information you feel is relevant. Formal complaints will be responded to in writing within 30 days. Send formal complaints to:

United Behavioral Health
Post Office Box 32040
Oakland, CA 94604-3340

Appeals (Grievance)

Your Right to an Internal Appeal (Grievance)

If you disagree with an adverse determination made by United Behavioral Health, you have the right to request an internal appeal review of that determination. In most cases, United Behavioral Health provides one level of internal review. However, in certain cases in which new medical information becomes available after an adverse determination has been made following an internal appeal

review, a reconsideration of the adverse determination may be available as outlined in your Evidence of Coverage. After the internal review options have been exhausted, you are then eligible for an External Review Process if you still disagree with the results of the internal review.

An adverse determination is a determination by United Behavioral Health to deny, reduce, modify or terminate benefits for inpatient admission, continued inpatient stay, or any other behavioral health care service, for failure to meet the requirements for a *covered service.*

How to Initiate a First Level Internal Appeal (Grievance) Review

You or your authorized representative may submit an appeal request in writing, by calling the UBH toll-free telephone number or using the fax number, all of which are listed below. You have up to 180 days from the date you received the adverse determination letter to request a first level internal appeal. Send written requests to:

United Behavioral Health, Appeals Unit
Post Office Box 32040
Oakland, CA 94604-3340
Fax: 1-415-547-6259
1-800-888-2998, extension 5182

Appeal requests should include:

- the member's name, Social Security Number, and group policy number;
- the service which is the subject of the adverse determination;
- the reasons why you feel benefit coverage should be approved;
- any available medical information to support your reasons for reversing the adverse determination; and
- a completed authorization release, enclosed, to enable UBH to review your medical information.

You will receive a written acknowledgement of your appeal request within five (5) days of receipt of your written request. Oral requests will be documented and a copy will be forwarded to you within 48 hours of receiving your oral request.

Internal Appeal (Grievance) Review

An individual who did not participate in the adverse determination will review your appeal. This individual will be an actively practicing health care professional in the same or similar specialty that typically provides the treatment that is the subject of the appeal. United Behavioral Health will notify you or your authorized representative of the decision in writing within 30 days of receipt of your oral or written appeal.

An expedited internal review is available if you are receiving ongoing treatment or services in a hospital at the time of the adverse determination. You have the right to receive coverage of the disputed treatment or service until the completion of the internal appeal process. You or your authorized representative may request an expedited internal appeal by calling the toll-free number listed in the "How to Initiate the First Level Internal Appeal (Grievance)" section above.

A determination will be made and verbal notice provided within 24 hours and a written notification will follow to you and your physician within **one (1) business day**. The written notice will be provided prior to the anticipated discharge. If you are dissatisfied with the outcome of the determination, you have the right to an expedited external review and the right to request continuation of coverage for the services. Please refer to the section below titled "External Review Process" for instructions.

If you have a terminal illness and you disagree with an adverse determination made by United Behavioral Health, you have the right to request an expedited internal appeal review of that determination.

External Review Process

You or your authorized representative or the attending provider may request an external review of an adverse determination that was a result of the internal appeal review. You or your authorized representative may request access to any medical information in the possession or control of the carrier relating to the insured. In order to request an external review, you must:

- Submit your request in writing within 45 days of your receipt of the adverse determination resulting from the internal review
- Complete the Massachusetts Request for External Appeal form and include the signed authorization of release of medical records
- Submit the form and appropriate fee to the Office of Patient Protection and include a copy of the written adverse determination notice resulting from the internal review to:

The Commonwealth of Massachusetts
Department of Public Health
Office of Patient Protection
250 Washington Street, 2nd Floor
Boston, MA 02108

You have the right to request an expedited external review. This request must be in writing from a physician, stating that delay in providing or continuing health care services, which are the subject of a final adverse determination, would pose a serious and immediate threat to the health of the insured.

The Office of Patient Protection will screen your request for an appeal within 48 hours of receipt for expedited requests, and five (5) business days of receipt for all other requests. Notification of ineligible requests shall be communicated to the member, the member's authorized representative and United Behavioral Health within 72 hours of receipt for an expedited request; and within 10 business days of receipt for all other requests and shall include the reason for the ineligible determination.

If your request is accepted, United Behavioral Health will forward the member's medical and treatment records and a copy of the Evidence of Coverage applicable to the member, to the external review agency assigned by the Office of Patient Protection within three (3) business days or within 24 hours for expedited requests.

For non-expedited reviews, the external review agency will make a decision within 60 business days of receipt of the referral from the Office of Patient Protection. For expedited reviews, the external review agency will make a decision within five (5) business days of receipt from the Office of Patient Protection. The decision will be in writing, will identify the decision, set forth the medical and scientific reasons for the decision and will be binding. If additional time is needed, the external review agency may extend the time period for an additional 15 business days and will notify all parties of that extension.

How to Contact the Office of Patient Protection at the Department of Public Health

You may contact the Department of Public Health with any questions at: 1-800-436-7757 or via FAX at 1-617-624-5046. You may also access the Department of Public Health's Web Site for additional copies of the required forms at: **http://www.mass.gov/dph/opp.**

Filing Claims

Network providers and facilities will file your claim for you. You are financially responsible for *deductibles* and *copayments*.

Out-of-network providers are not required to process claims on your behalf; you must submit the claims yourself. You are responsible for all *coinsurance* and *deductibles*. Send the *out-of-network provider's* itemized bill and a completed CMS 1500 claim form, with your name, address, and GIC ID number to:

United Behavioral Health
GIC Claims
Post Office Box 30755
Salt Lake City, UT 84130-0755

The CMS 1500 form is available from your provider. Claims must be received by UBH within 15 months of the date of service for you or a covered dependent. You must be eligible for coverage on the date you received care. All claims are confidential.

Coordination of Benefits

All benefits under this plan are subject to *coordination of benefits*, which determines whether your mental health or substance abuse care is partially or fully covered by another benefit plan. UBH may request information from you about other health insurance coverage in order to process your claim correctly.

For More Information

UBH customer service staff is available to help you. Call 1-888-610-9039 toll free (TDD: 1-800-842-9489) for assistance Monday through Friday, from 9 a.m. to 8 p.m. Eastern Time.

PART II – Benefit Highlights

Definitions of UBH Terms

Allowed Charges means charges conform to UBH negotiated fee maximums or reasonable and customary rates. If the cost of treatment for out-of-network care exceeds the *allowed charges*, the covered person may be responsible for the difference.

In Massachusetts, if you choose to use a provider other than a *network provider*, you are responsible for the *coinsurance* amounts up to the allowed charge. Providers of services in Massachusetts are prohibited by law from billing you for amount in excess of *allowed charges*.

Outside Massachusetts, if you choose to use a provider other than a *network provider*, you are responsible for amounts in excess of the *allowed charge*. Amounts in excess of the *allowed charge* are not applied toward satisfying the *deductible*, *coinsurance* or *out-of-pocket maximum*.

Appeal (Grievance) means a formal request for UBH to reconsider any adverse determination/denial of coverage, either concurrently or retrospectively, for admissions, continued stays, levels of care, procedures, or services.

Case Management means a system of *continuing review* by a UBH clinical case manager, using objective clinical criteria, to determine if treatment is appropriate and is a *covered service* according to the plan of benefits for a covered diagnostic condition.

Words in italics are defined in Part II

Coinsurance means the limit of coverage by the plan to a certain percentage of provider costs and fees, such as 80%. The remaining percentage is paid by the covered person. The provider is responsible for billing the member for the remaining percentage.

Complaint means a verbal or written statement of dissatisfaction arising from a perceived adverse administrative action, decision, or policy by UBH.

Continuing Review/Concurrent Review means an assessment of the care while it is being delivered and the proposed treatment plan for future care, conducted at periodic intervals by a clinical case manager to determine the appropriateness of continued care.

Coordination of Benefits (COB) means a methodology which determines the order and proportion of insurance payment when a covered person has coverage through more than one insurer. The regulations define which organization has primary responsibility for payment and which organization has secondary responsibility for any remaining charges not covered by the "primary plan."

Copayment means a fixed dollar amount that a covered person must pay out of his or her own pocket.

Covered Services are services and supplies provided for the purpose of preventing, diagnosing or treating a behavioral disorder, psychological injury or substance abuse addiction and which are described in the section titled "What This Plan Pays," and not excluded under the section titled "What's Not Covered – Exclusions."

Cross Accumulation means the sum of applicable expenses paid by a covered person to determine whether a *deductible* or *out-of-pocket maximum* has been reached.

Deductible means the designated amount that a covered person must pay for any charges before insurance coverage applies.

Intermediate Care means care that is more intensive than traditional outpatient treatment but less intensive than 24-hour hospitalization. Some examples are residential treatment, group homes, halfway houses, therapeutic foster care, day or partial hospital programs, or structured outpatient programs.

Network Provider is a provider who participates in the United Behavioral Health network.

Non-Notification Penalty means the amount charged when you fail to *precertify* care. It does not count towards the *out-of-pocket maximum*.

Out-of-Network Provider is a provider who does not participate in the United Behavioral Health network.

Out-of-Pocket Maximum means the maximum amount you will pay in *coinsurance* and *copayments* for your mental health and substance abuse care in one calendar year. When you have met your *out-of-pocket maximum*, all care will be covered at 100% of the *allowed charge* until the end of that calendar year. This maximum does not include the *non-notification penalty*, the out-of-network calendar year *deductible*, the out-of-network inpatient *deductible*, charges for care not deemed to be a *covered service*, and charges in excess of UBH's *allowed charges*.

Precertification (Precertify) is the process of registering for services with UBH prior to seeking EAP, mental health, and substance abuse care. All *precertification* is performed by *UBH clinicians*.

(definitions continued on page 82)

Benefits Chart

The following chart summarizes certain benefits available to you. Be sure to read Part III, which describes your benefits in greater detail and notes some important restrictions. Remember, in order to receive the maximum benefits, you must *precertify* your care with UBH before you begin treatment. For assistance, call toll-free 24 hours a day, seven days a week: 1-888-610-9039 (TDD: 1-800-842-9489).

Covered Services	Network Benefits	Out-of-Network Benefits
Annual Deductible	None	$150 per person (a,b) $300 per family (a)
Annual *Out-of-Pocket Maximum*	$1,000 per person (a) $2,000 per family (a)	$3,000 per person (a) No family maximum
Benefit Maximums	Unlimited	See *Covered Service* Benefit Maximum
Inpatient Care (Benefit levels listed below apply after applicable *deductibles* are met)		
Deductible	$200 per calendar quarter (a)	$150 per admission (applies after annual *deductible* is met) (a)
Mental Health General Hospital Psychiatric Hospital **Substance Abuse (c)** General Hospital or Substance Abuse Facility	Full Coverage	80% of *allowed* charges
All hospital care must be *precertified*. Emergency admissions must be *precertified* within 24 hours to receive maximum benefits. The n*on-notification penalty* for failure to *precertify* care is $200. The n*on-notification penalty* does not count toward *out-of-pocket maximums* or *deductibles*.		
Intermediate Care (d) (Intensive outpatient care, partial hospitalization, group home, therapeutic foster care, residential treatment and other acute care alternatives)	Full Coverage	80% of *allowed charges* after *deductible* is met

Covered Services	Network Benefits	Out-of-Network Benefits
Outpatient Care (d) (e) (f) (g) – Mental Health, Substance Abuse and *Enrollee Assistance Program (EAP)*		
First four visits (Individual and/or Group therapy)	Full Coverage	80% of *allowed charges* (e) (f)
Visits 5 to 15 (Individual therapy)	Full coverage after $15 copay per visit	80% of *allowed charges* (e) (f)
Visits 16 and over (Individual therapy)	Full coverage after $15 copay per visit	50% of *allowed charges* (e) (g)
EAP *Non-notification penalty* reduces benefit to zero: no benefits paid.		
Visits 5 to 15 (Group therapy)	Full coverage after $10 copay per visit	80% of *allowed charges* (e) (f)
Visits 16 and over (Group therapy)	Full coverage after $10 copay per visit	50% of *allowed charges* (e) (g)
Medication Management: (15-30 minute psychiatrist visit)	Full coverage after $5 copay per visit	80% of *allowed charges* for outpatient visits 1-15 (e) (f) 50% of *allowed charges* for outpatient visits 16 and over (e) (g)
In-Home Mental Health Care	Full coverage	80% of *allowed charges* for outpatient visits 1-15 (e) (f) 50% of *allowed charges* for outpatient visits 16 and over (e) (g)
Drug Testing (as an adjunct to Substance Abuse treatment)	Full coverage	No coverage
Non-notification penalty reduces benefit to zero: no benefits paid.		
Provider Eligibility – Provider must be licensed in one of these disciplines		MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS (h)

(a) Separate from medical deductible and medical out-of-pocket maximum. Network and Out-of-Network out-of-pocket maximums do not cross accumulate.
(b) Cross accumulates with all Out-of-Network mental health and substance abuse benefit levels.
(c) Substance Abuse Rehabilitation Incentive Program: Members are reimbursed for inpatient and outpatient copays if they complete inpatient and post-discharge care.
(d) Treatment that is not precertified receives the Out-of-Network level reimbursement, except as noted in item (g) below.
(e) All Out-of-Network outpatient visits in a given benefit year, including mental health, substance abuse and EAP outpatient visits, medication management visits and in-home mental health care visits, are accumulated to determine the appropriate Out-of-Network level of reimbursement.
(f) No precertification is required for Out-of-Network outpatient visits 1 through 15, per benefit plan year.
(g) Out-of-Network outpatient visits 16 and over, per benefit plan year, are subject to the same precertification requirements as Network benefits in order to be eligible for coverage. If Out-of-Network outpatient visits 16 and over are not precertified, no benefit will be paid for those services.
(h) Massachusetts independently licensed providers; psychiatrists, licensed clinical social workers, psychiatric nurse clinical specialist and allied mental health professionals.

All benefits are paid in accordance with the Allowable Charges. Refer to the Glossary for the definition of Allowable Charges.

Out-of-Network services, except for Out-of-Network outpatient visits 16 and over, are subject to Utilization Review at the time a claim is submitted for payment in order to determine if the services meet the Clinical Necessity criteria for Behavioral Health Services. Out-of-Network outpatient visits 16 and over require precertification in order to be eligible for coverage.

UBH Clinician refers to the staff member who *precertifies* EAP, mental health, and substance abuse services. *UBH clinicians* must have the following qualifications: Master's degree in psychology, social work, or a related field; three or more years of clinical experience; Certified Employee Assistance Professionals (CEAP) certification or eligibility; and a comprehensive understanding of the full range of EAP services for employees and employers, including workplace and personal concerns.

What This Plan Pays

The Plan pays for the following services:

- **Outpatient Care** – Individual or group sessions with a therapist, usually conducted once a week, in the provider's office or facility.
- **Intermediate Care** – Care that is more intensive than traditional outpatient services, but less intensive than 24-hour hospitalization. Some examples are residential treatment, group homes, halfway houses, therapeutic foster care, day/partial hospitals, or structured outpatient programs.
- **In-Home Care** – A licensed mental health professional visits the patient in his or her home.
- **Inpatient Care** – Treatment in a hospital or substance abuse facility.
- **Detoxification** – Medically supervised withdrawal from an addictive chemical substance, which may be done in a substance abuse facility.
- **Drug Testing** – *Precertified* drug testing is covered as an adjunct to substance abuse treatment.

The Plan also covers:

- **Enrollee Assistance Program** – Short-term counseling or other services that focus on problems of daily living, such as marital problems, conflicts at work, legal or financial difficulties, and dependent care needs.
- **www.liveandworkwell.com** – An interactive web site offering a large collection of wellness articles, service databases including a UBH Massachusetts *network provider* directory, tools, financial calculators and expert chats. To enter the site, log on to www.liveandworkwell.com and enter access code 10910.

These services are subject to certain Exclusions, which are found in Part III.

PART III – Benefits Explained

Mental Health and Substance Abuse Benefits

Network Services

In order to receive maximum network benefits for mental health, substance abuse and EAP services you must call United Behavioral Health toll free at 1-888-610-9039 (TDD: 1-800-842-9489) to *precertify* care and obtain a referral to a *network provider*.

Precertified network services are paid at 100% after appropriate *deductible* and *copayment* (see schedule on page 80). The calendar year *out-of-pocket maximum* for network services is $1,000 per person and $2,000 per family.

The following do not count toward the *out-of-pocket maximum*:

- *Non-notification penalties*
- Cost of treatment subject to exclusions

If you fail to *precertify* your care, you may be charged a *non-notification penalty*. The *non-notification penalty* for each type of service is listed in the Benefit Highlights chart on pages 80-81, and in the following descriptions of services.

Network Benefits

Outpatient Care – The *copayment* schedule for network outpatient *covered services* is shown below:

Visits 1-4	No *copayment*
Visits 5 and over (individual)	$15 *copayment*
Visits 5 and over (group)	$10 *copayment*

Outpatient care *cross accumulates* with EAP services. (See page 85 for a full explanation of EAP services.) You have four sessions with no *copayment* for either EAP, mental health, or substance abuse services.

Failure to *precertify* outpatient care results in a benefit reduction to the out-of-network level of reimbursement, and in some cases may result in no coverage. Please refer to the section titled Out-of-network Services for further details.

In-Home Care – In-home care is a *covered service* if *precertified*. Treatment that is *not precertified* but deemed to be a *covered service* receives out-of-network level reimbursement, and in some cases may result in no coverage. Please refer to the section titled Out-of-network Services for further details.

Intermediate Care – *Intermediate care* is covered if *precertified*. This includes, but is not limited to, 24-hour *intermediate care* facilities (for example, residential treatment, group homes, halfway houses, therapeutic foster care, day/partial hospital, and structured outpatient treatment programs). *Intermediate care* that is not *precertified* but deemed to be a *covered service* receives out-of-network level reimbursement.

Inpatient Care – Network inpatient care deemed to be a *covered service* in a general or psychiatric hospital, or substance abuse facility if *precertified* is covered at 100% after a $200 per calendar quarter deductible. There is a $200 *non-notification penalty* for failure to *precertify* inpatient care.

Drug Testing – *Precertified* drug testing is covered as an adjunct to substance abuse treatment.

Substance Abuse Rehabilitation Incentive Program – Members who successfully complete all prescribed inpatient treatment and aftercare rehabilitation for substance abuse can apply for a refund for all inpatient and outpatient copays associated with their treatment.

Psychological Testing – Psychological testing, including neuropsychological testing, that is deemed to be a *covered service* is covered when *precertified*. Psychological testing that is not *precertified*, yet deemed to be a *covered service*, receives out-of-network level reimbursement.

Out-of-Network Services

Care from an *out-of-network provider* is paid at a lower level than network care. Out-of-network care is subject to *deductibles*, *copayments*, and *coinsurance*.

Benefits are paid based on *allowed charges* that are UBH reasonable and customary fees or negotiated fee maximums. If your *out-of-network provider* or facility charges more than these *allowed charges*, you may be responsible for the difference, in addition to any amount not covered by the benefit.

Out-of-network mental health and substance abuse treatment is subject to a $150 per person/$300 per family calendar year

deductible. Calendar year *deductibles* must be met prior to inpatient *deductibles* and *cross accumulate* between all out-of-network mental health and substance abuse benefit levels.

The *out-of-pocket maximum* for out-of-network care is $3,000 per person, with no family maximum.

The following do not count toward the *out-of-pocket maximum*:

- Out-of-network calendar year *deductibles*
- Out-of-network inpatient *deductibles*
- *Non-notification penalties*
- Cost of treatment found not to be a *covered service*
- Charges in excess of UBH's *allowed charges*

All out-of-network outpatient visits in a calendar year, including mental health, substance abuse and EAP outpatient visits, medication management visits and in-home mental health care visits, are accumulated to determine the appropriate out-of-network level of reimbursement. There is no longer a 15 visit per year maximum on out-of-network outpatient visits, but there are different levels of reimbursement for out-of-network outpatient visits 1-15 and visits 16 and over. Also, all out-of-network outpatient visits after visit 15 must be *precertified* in order to be eligible for reimbursement. Charges paid by the covered person for out-of-network outpatient care, if determined to be a *covered service* and if *precertified* when required, do count toward the *out-of-pocket maximum*. If it is determined that care was not a *covered service*, no benefits will be paid. If you fail to *precertify* services, your benefits may be subject to a non-notification penalty and/or may be ineligible for coverage.

Out-of-Network Benefits

Outpatient Care – Out-of-network outpatient visits 1 through 15, deemed to be a *covered service*, are paid at 80% of UBH's *allowed charges*, after your $150 annual *deductible* is met. Outpatient visits 16 and over that are *precertified* are paid at 50% of UBH's *allowed charges*. Out-of-network, outpatient visits 1 through 15 do not require *precertification*; however, all outpatient, out-of-network visits beyond session 15 require *precertification* with a UBH Clinician (call UBH toll free at 1-888-610-9039).

In-Home Care – Included in outpatient care visits and accumulates with the other outpatient visits to determine the appropriate level of reimbursement. Visits up to session 15, deemed to be a *covered service*, are paid at 80% of UBH's *allowed charges*, after the appropriate annual *deductible* has been met. In-home care beyond session 15 requires *precertification*. *Precertified out-of-network* visits 16 and over are paid at 50% of UBH's *allowed charges*.

Intermediate Care – *Intermediate care*, deemed to be a *covered service*, is paid at 80% after appropriate annual *deductibles* have been met.

Inpatient Care – Out-of-network inpatient care, deemed to be a *covered service* for mental health care, is paid at 80% in a general and psychiatric hospital. Inpatient care for substance abuse treatment, deemed to be a *covered service*, is paid at 80% in a general hospital or substance abuse facility.

Each admission to a hospital or facility is subject to a $150 inpatient *deductible* per person in addition to the calendar year *deductible*. Failure to *precertify* inpatient care is subject to a *non-notification penalty* of

$200 if the UBH case manager determines that the care is a *covered service*. No benefits will be paid if it is found not to be a *covered service*.

Drug Testing – There is no coverage for out-of-network drug testing.

See pages 86-88 for a list of Exclusions.

Enrollee Assistance Program

The Enrollee Assistance Program can help with the following types of problems:

- Breakup of a relationship
- Divorce or separation
- Becoming a step-parent
- Helping children adjust to new family members
- Death of a friend or family member
- Communication problems
- Conflicts in relationships at work
- Legal difficulties
- Financial difficulties
- Child or elder-care needs
- Aging
- Traumatic events

To use your EAP benefit, call toll free 1-888-610-9039 (TDD: 1-800-842-9489). The procedures for *precertifying* EAP care and referral to an EAP provider are the same as for mental health and substance abuse services. You will be referred by a UBH clinician to a trained EAP provider and/or other specialized resource (e.g., attorneys, family mediators, dependent care services) in your community. The UBH clinician may recommend mental health and substance abuse services if the problem seems to require more extensive help than EAP services can provide.

LawPhone

LawPhone is a free legal referral service for Commonwealth enrollees. As a member of the Commonwealth Indemnity Plan Community Choice, you have free access to LawPhone Legal Referral Service offered by UBH. This service provides:

- Free, unlimited telephone consultations with an attorney
- a free, 30-minute "face-to-face" consultation with an attorney
- a 25% discount for additional services provided by an attorney

For more information or to be connected with LawPhone, call UBH toll free at 1-888-610-9039 (TDD: 1-800-842-9489).

Employee Assistance Program

In addition, the Commonwealth offers an Employee Assistance Program as a resource to all agencies. All state employees can access critical incident debriefing services at no cost to the individual. Managers and supervisors can receive confidential consultations and resource recommendations for dealing with employee issues such as low morale, disruptive workplace behavior, mental illness and substance abuse.

Network Benefits

EAP network benefits are paid according to the outpatient *copayment* schedule and *cross accumulate* with those benefits. No *copayment* is required for the first four visits, provided they have not been used for mental health and substance abuse care. If you use your first four visits as EAP sessions, all additional sessions for mental health and substance abuse services will be subject to the *copayment* schedule for outpatient treatment set forth on page 83.

Out-of-Network Benefits

There is no coverage for out-of-network EAP services.

What's Not Covered – Exclusions

The following exclusions apply regardless of whether the services, supplies, or treatment described in this section are recommended or prescribed by the Covered Person's provider and/or are the only available treatment options for the Covered Person's condition.

This benefit plan does not cover services, supplies or treatment relating to, arising out of, or given in connection with the following:

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM).
- Prescription drugs or over the counter drugs and treatments. See pages 65-70 in this handbook for prescription drug coverage information.
- Services or supplies for MHSA treatment that, in the reasonable judgment of UBH are any of the following:
  - not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
  - not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
  - not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome;
  - typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or
  - not consistent with UBH's Level of Care Guidelines or best practices as modified from time to time.

UBH may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.

- Unproven, Investigational or Experimental Services – Services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a *Covered Service* if the service, treatment, or device is considered to be unproven, investigational, or experimental.
- Custodial Care except for the acute stabilization of the Covered Person and returning the Covered Person back to his or her baseline levels of individual functioning. Care is determined to be custodial when:
  - it provides a protected, controlled environment for the primary purpose of protective detention and/or providing services necessary to assure the Covered Person's competent functioning in activities of daily living; or

  - it is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary for the Covered Person to function outside a structured environment. This applies to Covered Persons for whom there is little expectation of improvement in spite of any and all treatment attempts.
- Covered Persons whose repeated and volitional non-compliance with treatment recommendations result in a situation in which there can be no reasonable expectation of a successful outcome.
- Neuropsychological testing for the diagnosis of attention deficit disorder.
- Examinations or treatment, unless it otherwise qualifies as Behavioral Health Services, when:
  - required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;
  - ordered by a court except as required by law;
  - conducted for purposes of medical research; or
  - required to obtain or maintain a license of any type.
- Herbal medicine, holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Nutritional counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.
- Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies.
- Services or treatment rendered by unlicensed providers, including pastoral counselors (except as required by law), or which are outside the scope of the providers' licensure.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.
- Light boxes and other equipment, including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while confined in a facility.
- Surgical procedures including but not limited to gender reassignment operations.
- Smoking cessation related services and supplies.
- Travel or transportation expenses unless UBH has requested and arranged for the Covered Person to be transferred by ambulance from one facility to another.
- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with the same legal residence as the Covered Person.

- Behavioral Health Services for which the Covered Person has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
- Charges in excess of any specified Plan limitations.
- Any charges for missed appointments.
- Any charges for record processing except as required by law.
- Services provided under another plan and services or treatment for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or a similar law is optional for the Covered Person because the Covered Person could elect it or could have it elected for him or her, benefits will not be paid if coverage would have been available under the workers' compensation or similar law had that coverage been elected.
- Behavioral Health Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country when the Covered Person is legally entitled to other coverage.
- Treatment or services received prior to the Covered Person being eligible for coverage under the Plan or after the date the Covered Person's coverage under the Plan ends.

Commonwealth Indemnity Plan
Administered by UNICARE

Appendices

MEMBER CONFIDENTIALITY STATEMENT

UniCare Life & Health Insurance Company
Commonwealth Indemnity Plan Community Choice

UniCare, the administrator for the Commonwealth Indemnity Plan Community Choice, protects the confidentiality of its members' personal financial and health information as required by law, accreditation standards and its internal policies and procedures. This Member Confidentiality Statement explains your rights, our legal duties and our privacy practices.

Your Financial Information

In order to conduct health insurance activities, we collect and use several different types of financial information. This includes information that you provide directly to us on applications or other forms, such as your name, address, age and information about dependents. We accumulate information about your transactions with our affiliates, others, or us such as policy coverage, premiums and payment history. We also retain any information we may receive from a consumer-reporting agency such as your credit history.

We use physical, electronic and procedural safeguards to protect your confidential information. We make it available only to our employees, affiliates or others who need it to service or maintain your policy, to conduct insurance transactions and functions, or for other legally permitted or required purposes.

Your Health Information

THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We collect, use and disclose information provided by and about you for health care payment and operations, or when we are otherwise permitted or required by law to do so.

For Payment: We may use and disclose information about you in managing your account or benefits, and paying claims for medical care you receive through your plan. For example, we maintain information about your premium and deductible payments. We may also provide information to a doctor's office to confirm your eligibility for benefits, or we may ask a hospital for details about your treatment so that we may review and pay the claim for your care.

For Health Care Operations: We may use and disclose medical information about you for our operations. For example, we may use information about you to review the quality of care and services you receive; to provide you case management or care coordination services, such as for asthma, diabetes or traumatic injury; or to seek accreditation.

We may contact you to provide information about treatment alternatives or other health-related benefits and services. For example, when you or your dependents reach a certain age, we may notify you about additional products or programs for which you may become eligible, such as Medicare supplements or individual coverage. We may also notify you about routine medical check-ups and tests. We may, in the case of some group health plans, share limited health information with your employer or other organizations that help pay for your membership in the plan, in order to enroll you, or to permit the plan sponsor to perform plan administrative

functions. Plan sponsors that receive this information are required by law to have safeguards in place to protect it from inappropriate uses.

As Permitted or Required by Law:
Information about you may be used or disclosed to regulatory agencies, such as during audits, licensure or other proceedings; for administrative or judicial proceedings; to public health authorities; or to law enforcement officials, such as to comply with a court order or subpoena.

Authorization: Other uses and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. We will then stop using your information for that purpose. However, if we have already used your information based on your authorization, you cannot take back your agreement for those past situations.

Your Rights

Under the Health Insurance Portability and Accountability Act (HIPAA) regulations effective April 2003, you have the following rights over your health information. Under these rules, you have the right to:

- Send us a written request to see or get a copy of information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as your physician or hospital.

- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests.

- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address, if communications to your home address could endanger you.

- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care operations, or the law otherwise restricts the accounting. We are not required to give you a list of disclosures made before April 14, 2003.

Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with us, or with the federal government. You will not be penalized for filing a complaint.

Copies and Changes

You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

We reserve the right to revise this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. We will communicate any changes to our notice through subscriber newsletters, direct mail, and/or our web site.

Contact Information

If you want to exercise your rights under this notice or if you wish to communicate with us about privacy issues or to file a complaint with us, please contact the Commonwealth Service Center at 1-800-442-9300.

What You Should Know When You Use Non-Massachusetts Providers

This appendix contains important information about how the Community Choice Plan pays for services you receive from health care providers located outside of Massachusetts.

Reimbursement to Non-Massachusetts Providers

If you use a non-Massachusetts provider for any reason – including emergency care – you could be subject to balance billing. Balance billing is the practice by health care providers of billing patients for charges that exceed the amount paid by a patient's health plan for services rendered. For example, if your doctor bills your health plan $90 for your office visit and your insurance company allows $75 for the office visit, some physicians may balance bill you for the difference of $15.

The following information explains how the Plan reimburses non-Massachusetts providers and how you may be able to manage or avoid balance billing by these providers.

The Plan pays non-Massachusetts providers according to fee schedules that establish the reasonable and customary allowed rates for payment of services. The payments in the fee schedules are consistent with what other plans pay providers. Charges in excess of the fee schedule amounts will not be considered for payment, as they will exceed these allowed amounts. A provider might balance bill you for the difference between the payment made by the Plan according to the fee schedules and the amount the provider charged.

Ways to Avoid Balance Billing

Here are two ways you can manage or even avoid balance billing:

Use Massachusetts Providers for Your Health Care Whenever Possible – If you are planning any elective health care services, or need to schedule a medical or surgical procedure, you should consider using Massachusetts providers for that care whenever possible. These providers are prohibited by Massachusetts law from balance billing members of the Community Choice Plan for amounts above the allowed amounts established in the fee schedules.

The Plan encourages you to plan ahead, scheduling medical care in Massachusetts before you go away, or upon your return. This will guarantee that you don't get balance billed.

Discuss the Balance Bill with Your Non-Massachusetts Provider – Ask your provider to consider accepting the allowed amount from the Plan as payment in full for his or her services. The Plan's fee schedules for out-of-state providers are intended to provide adequate compensation for services, usually at a level similar to – and sometimes higher than – what providers are receiving from many other health insurance plans in the area. Additionally, the Plan pays providers promptly; nearly 100 percent of provider claims are paid within 14 days of their receipt.

(continued on next page)

Using the Plan's Out-of-state Contracted Providers to Avoid Balance Billing

You or your eligible dependent may be able to participate in the Plan's program to help you avoid balance billing if you meet one of the following criteria:

1. you reside outside of Massachusetts – either permanently or for more than four consecutive weeks of the year – and receive services from non-Massachusetts providers, or
2. you have an eligible dependent who attends school outside of Massachusetts who receives services from non-Massachusetts providers

The Plan allows access to contracted providers outside of Massachusetts that you or your eligible student dependent can use for health care services, depending on where you or your dependent lives. These providers accept the Plan's fee schedules as payment in full and agree not to balance bill you. For more information on these contracted providers and how to use them, contact the Plan.

If You Live Out-of-State Temporarily

If you or your eligible child dependent plan to reside outside your home state for more than four consecutive weeks of the year, please call the Commonwealth Service Center at 1-800-442-9300 to report your new address. Or download the temporary change of address form from the Plan's web site at **www.unicare-cip.com** from the "Forms and Documents" web page.

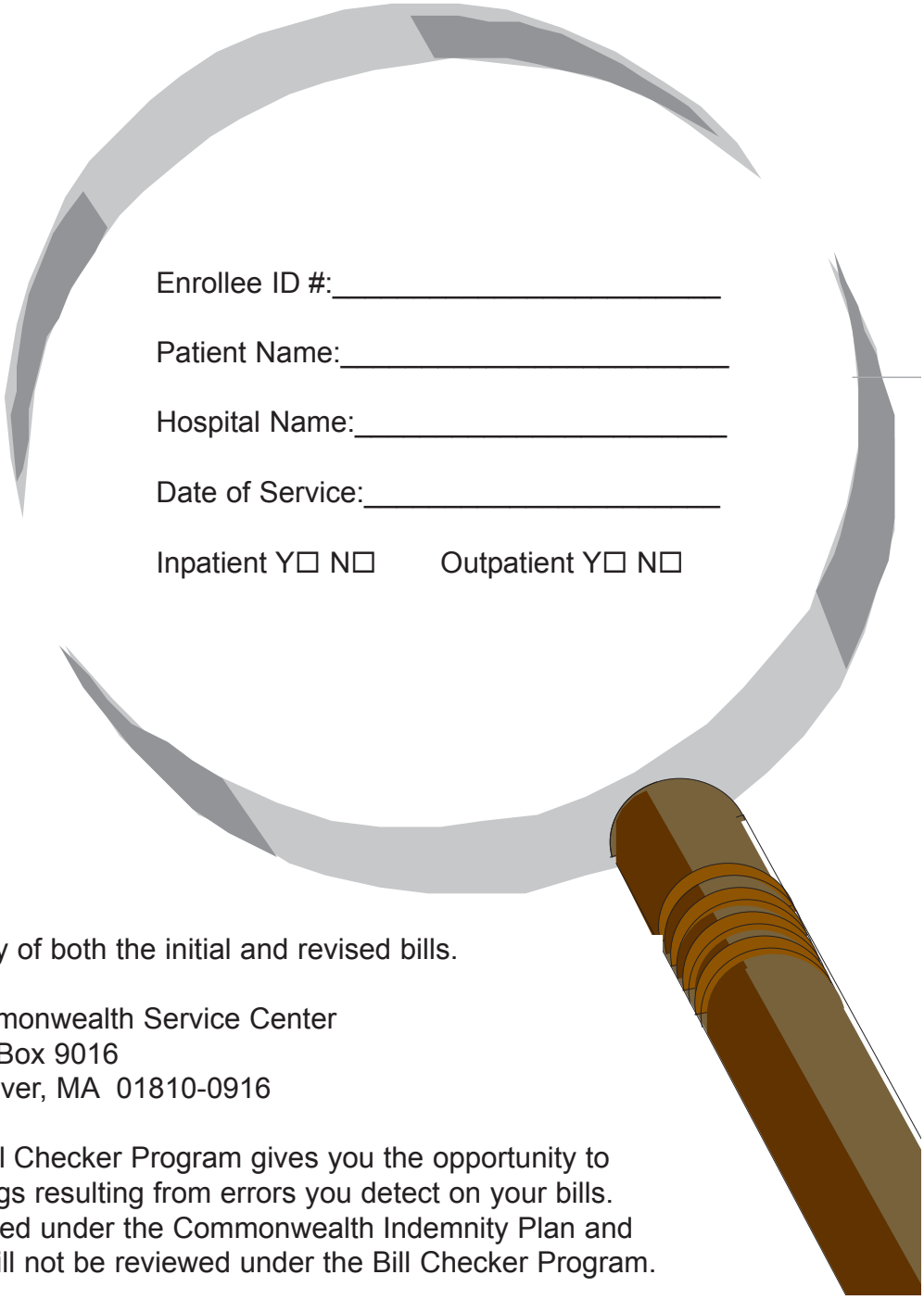
For More Information

For additional information about how to avoid being balance billed by non-Massachusetts providers, contact the Commonwealth Service Center at 1-800-442-9300. You can also e-mail the Plan from its web site at **www.unicare-cip.com**; click on "Contact Us."

Commonwealth Indemnity Plan
Administered by UNICARE

UniCare.

BILL CHECKER PROGRAM



Enrollee ID #:_____

Patient Name:_____

Hospital Name:_____

Date of Service:_____

Inpatient Y☐ N☐ Outpatient Y☐ N☐

Attach a photocopy of both the initial and revised bills.

Mail to: Commonwealth Service Center
P.O. Box 9016
Andover, MA 01810-0916

Remember, the Bill Checker Program gives you the opportunity to share in any savings resulting from errors you detect on your bills. Services not covered under the Commonwealth Indemnity Plan and duplicate claims will not be reviewed under the Bill Checker Program.

Claims form to be inserted on this page

COMMONWEALTH INDEMNITY PLAN

Community Choice Hospital Listing

Hospital Listing

Attleboro, MA

Sturdy Memorial Hospital
211 Park Street
Attleboro, MA 02703
508-222-5200

Ayer, MA

Nashoba Valley Medical Center
200 Groton Road
Ayer, MA 01432
978-784-9000

Beverly, MA

Beverly Hospital
85 Herrick Street
Beverly, MA 01915
978-922-3000

Boston, MA

Beth Israel Deaconess Medical Center
330 Brookline Avenue
Boston, MA 02215
617-667-8000

Children's Hospital
300 Longwood Avenue
Boston, MA 02115
617-355-6000

Boston, MA (cont'd)

New England Baptist Hospital
125 Parker Hill Avenue
Boston, MA 02120
617-754-5800

Brockton, MA

Brockton Hospital
680 Centre Street
Brockton, MA 02402
508-941-7000

Clinton, MA

Clinton Hospital
201 Highland Street
Clinton, MA 01510
978-368-3000

Concord, MA

Emerson Hospital
133 Old Road to Nine Acre Corner
Concord, MA 01742
978-369-1400

Framingham, MA

MetroWest Medical Center
Framingham Union Campus
115 Lincoln Street
Framingham, MA 01701
508-383-1000

Gardner, MA

Heywood Hospital
242 Green Street
Gardner, MA 01440
978-632-3420

Gloucester, MA

Addison Gilbert Hospital
298 Washington Street
Gloucester, MA 01930
978-283-4000

Great Barrington, MA

Fairview Hospital
29 Lewis Avenue
Great Barrington, MA 01230
413-528-0790

Greenfield, MA

Franklin Medical Center
164 High Street
Greenfield, MA 01301
413-773-0211

Haverhill, MA

Merrimack Valley Hospital
140 Lincoln Avenue
Haverhill, MA 01830
978-374-2000

Lowell, MA

Saints Memorial Medical Center
One Hospital Drive
Lowell, MA 01852
978-458-1411

Lynn, MA

North Shore Medical Center
Union Campus
500 Lynnfield Street
Lynn, MA 01904
781-581-9200

Marlborough, MA

Marlborough Hospital
57 Union Street
Marlborough, MA 01752
508-481-5000

Medford, MA

Lawrence Memorial Hospital
170 Governors Avenue
Medford, MA 02155
781-306-6000

Melrose, MA

Melrose-Wakefield Hospital
585 Lebanon Street
Melrose, MA 02176
781-979-3000

Milford, MA

Milford-Whitinsville Regional Hospital
14 Prospect Street
Milford, MA 01757
508-473-1190

Milton, MA

Milton Hospital
92 Highland Street
Milton, MA 02186
617-696-4600

Natick, MA

MetroWest Medical Center
Leonard Morse Campus
67 Union Street
Natick, MA 01760
508-650-7000

Needham, MA

Beth Israel Deaconess Hospital
Needham Campus
148 Chestnut Street
Needham, MA 02192
781-453-3000

New Bedford, MA

St. Luke's Hospital
101 Page Street
New Bedford, MA 02740
508-997-1515

Newburyport, MA

Anna Jaques Hospital
25 Highland Avenue
Newburyport, MA 01950
978-463-1000

North Adams, MA

North Adams Regional Hospital
71 Hospital Avenue
North Adams, MA 01247
413-664-5000

Norwood, MA

Caritas Norwood Hospital
800 Washington Street
Norwood, MA 02062
781-769-4000

Oak Bluffs, MA

Martha's Vineyard Community Hospital
One Hospital Road
Oak Bluffs, MA 02568
508-693-0410

Palmer, MA

Wing Memorial Hospital
& Medical Centers
40 Wright Street
Palmer, MA 01069
413-283-7651

Plymouth, MA

Jordan Hospital
275 Sandwich Street
Plymouth, MA 02360
508-746-2001

Quincy, MA

Quincy Medical Center
114 Whitwell Street
Quincy, MA 02169
617-773-6100

Southbridge, MA

Harrington Memorial Hospital
100 South Street
Southbridge, MA 01550
508-765-9771

Springfield, MA

Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199
413-794-0000

Ware, MA

Mary Lane Hospital
85 South Street
Ware, MA 01082
413-967-6211

Wareham, MA

Tobey Hospital
43 High Street
Wareham, MA 02571
508-295-0880

Webster, MA

Hubbard Regional Hospital
340 Thompson Road
Webster, MA 01570
508-943-2600

Westfield, MA

Noble Hospital
115 West Silver Street
Westfield, MA 01085
413-568-2811

Winchester, MA

Winchester Hospital
41 Highland Avenue
Winchester, MA 01890
781-729-9000

Worcester, MA

Saint Vincent Hospital
20 Worcester Center Boulevard
Worcester, MA 01608
508-363-5000

Designated Hospitals for Select Complex Inpatient Procedures and High-Risk Maternity Care

There is a $200 deductible per calendar quarter for inpatient hospital care at all hospitals on the Community Choice listing. Community Choice also provides access to the following additional hospitals for certain complex procedures at the $200 deductible level, as indicated in the chart below.

	Coronary Artery Bypass*	Percutaneous Coronary Intervention*	Abdominal Aortic Aneurysm Repair*	Esophagectomy*	Pancreatic Resection*	High Risk Deliveries & Neonatal ICUs*	Spinal Fusion	Discectomy and Laminectomy	Hip Replacement	Knee Replacement	Cardiac Valve Procedures
Boston Medical Center	X			X	X	X		X			
Brigham and Women's Hospital	X	X	X	X	X	X	X	X	X	X	X
Cape Cod Hospital		X	X					X	X		
Caritas St. Elizabeth's Medical Center	X					X					
Lahey Clinic Hospital	X	X	X	X	X		X	X	X	X	X
Massachusetts General Hospital	X	X	X	X	X	X	X	X	X	X	X
Mount Auburn Hospital		X	X								
Tufts-New England Medical Center				X		X					
UMass Memorial Medical Center	X	X	X		X	X	X	X	X	X	X

* These procedures have been designated by the Leapfrog Group for Patient Safety as complex procedures that studies indicate are most safely performed at hospitals that meet the following criteria: 1) they have significant experience in performing the procedure, and 2) they comply with specific clinical practices established by the Leapfrog Group.

Index

Index

Commonwealth Service Center
P.O. Box 9016
Andover MA 01810-0916
1-800-442-9300
www.unicare-cip.com

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